# EXHIBIT 6

# DEPOSITION OF DR. LANDGRAF

**June 15, 2007**

**Pages 1 through 163**

**PREPARED BY:**

Haislip, Ragan, Green, Starkie & Watson, P.C.
566 South Perry Street
Post Office Box 62
Montgomery, AL 36104
Phone: (334) 263-4455
Fax: (334) 263-9167
E-mail: haislipragan@charter.net

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
EASTERN DIVISION

KYLE BENGSTON,
Plaintiff,
Vs. CIVIL ACTION NO.
3:06-CV-0059-MEF
DAVID BAZEMORE, O.D., and
WAL-MART STORES, INC.

Defendants.

* * * * * * * * * * * * *

DEPOSITION OF DR. THOMAS J. LANDGRAF, O.D.,

taken pursuant to stipulation and agreement before

Pamela A. Wilbanks, Registered Professional Reporter

and Commissioner for the State of Alabama at Large,

in the Law Offices of Adams, Umbach, Davidson &

White, 205 South Ninth Street, Auburn, Alabama, on

Friday, June 15, 2007, commencing at approximately

9:35 a.m.



APPEARANCES

FOR THE PLAINTIFF:
Mr. David W. Adams
THE NEWMAN LAW FIRM
Attorneys at Law
Park Plaza - Suite 150
178 South Main Street
Alpharetta, GA 30004

FOR THE DEFENDANTS:

Mr. Matthew W. White
Mr. Blake L. Oliver
ADAMS, UMBACH, DAVIDSON & WHITE
Attorneys at Law
205 South 9th Street
Opelika, Alabama 36803

* * * * * * * * * * * * *

EXAMINATION INDEX



* * * * * * * * * * * *

DEFENDANT'S EXHIBIT INDEX





STIPULATION

It is hereby stipulated and agreed by and between counsel representing the parties that the deposition of DR. THOMAS J. LANDGRAF, O.D. is taken pursuant to the Federal Rules of Civil Procedure and that said deposition may be taken before Pamela A. Wilbanks, Registered Professional Reporter and Commissioner for the State of Alabama at Large, without the formality of a commission, that objections to questions other than objections as to the form of the question need not be made at this time but may be reserved for a ruling at such time as the said deposition may be offered in evidence or used for any other purpose by either party provided for by the Statute.

It is further stipulated and agreed by and between counsel representing the parties in this case that the filing of said deposition is hereby waived and may be introduced at the trial of this case or used in any other manner by either party hereto provided for by the Statute regardless of the waiving of the filing of the same.

It is further stipulated and agreed by and



between the parties hereto and the witness that the signature of the witness to this deposition is hereby waived.

* * * * * * * * * * * * *

DR. THOMAS J. LANDGRAF, O.D.

The witness, after having first been duly sworn to speak the truth, the whole truth and nothing but the truth testified as follows:

EXAMINATION

BY MR. WHITE:

Q. If you would, please state your full name for the record, sir.

A. Thomas J. Landgraf.

Q. What does the "J" stand for?

A. Joseph.

Q. Dr. Landgraf -- Do you go by Dr. Landgraf?

A. Tom is fine, but Dr. Landgraf, sure.

Q. What do they refer to you at work?

A. Dr. Landgraf.

Q. You've given a deposition before, correct?

A. Yes.

Page 5

going to be asking you questions, and you're going to be responding to my questions. If I ask you a question today that you don't understand, if you would please ask me to rephrase it, I'll be glad to do that for you. Okay?

A. Yes.

(Defendant's Exhibit 1 marked for identification.)

Q. Let me show you what's marked as Defendant's Exhibit Number 1 which has an attachment that says Exhibit A to it.

MR. ADAMS: Let me address that real quick. I apologize. I did not share this with him prior to coming, and that's just my mistake. He did bring his entire file. He can access his e-mails, if necessary, the ones that he saved. Now, I'm not going to testify for him. I don't want you to think that, but I just wanted you to know that he has --

Page 6

a lot of these things he's brought with him, but the ones he hasn't brought with him, what I would propose that we do -- Some of these things don't apply, like he hasn't saved -- he indicated he might have saved a few depositions but not many.

In any event, anything that he hasn't brought with him, what I would propose is that we will produce it to you. If you need to ask him -- If it's anything after you receive it that you feel like you need to ask him about, I would propose that we take that up with a deposition by phone.

MR. WHITE: Okay. Let me go through the list, and I'll address them.

MR. ADAMS: And I'm sorry about that.

MR. WHITE: That's fine.

Page 7

Q. Number one -- I'm referring to Exhibit A on Defendant's Exhibit 1. It asked you to bring your entire file regarding Kyle Bengston. Have you done that?

A. Yes.

Q. Is that it there in front of you?

A. Yes.

Q. Do you mind if I flip through it and see what's in there?

A. No problem.

Q. What I'd like to do -- Let me just hold off for right now. Let me go through the list with you. Let me do this. I'm going to mark on your file folder Defendant's Exhibit 2. Is that okay with you?

A. Yes.

Q. And at some point today what I'd like to do is make a photocopy of the contents of your file folder regarding Mr. Bengston. Okay?

A. Okay.

Q. I'll stick this right here.

(Defendant's Exhibit 2 marked for identification.)

Page 8

Q. Let me go through the rest of this list.

Any and all correspondence and communications including e-mails between you and any attorney for Kyle Bengston.

Are any of those correspondence and communications listed in your file here marked as Defendant's Exhibit 2?

A. Yes.

Q. Some are?

A. Some are.

Q. Are there some that are not in that file?

A. Yes.

Q. Why would they not be in that file?

A. They are e-mails that I did not make copies of.

Q. E-mails from whom?

A. From Dave. Mr. Adams.

Q. Do you have any e-mails regarding this case from any other attorney other than Dave Adams?

A. No.

Q. How many such e-mails do you have?

A. Approximately ten.

Q. Are those saved on your computer back at your office?

A. Yes.
Q. When you get home, do you think you can print those out and provide them to us?
A. Yes.
MR. ADAMS: We'll get them to you.
Q. Number three is any and all notes and memoranda produced by you in relation to this matter.
Are there any such notes or memorandums in your file that's marked as Defendant's Exhibit 2?
A. Yes.
Q. And do you have any other notes or memorandum that are not included in Defendant's Exhibit 2?
A. No.
Q. Number four asks for any and all time records and billing records regarding this matter.
Are those records included in Defendant's Exhibit 2?
A. Some are.
Q. And some are not?
A. Some are not.
Q. Can you get us up-to-date time and billing



records as soon as you return to the office?
A. Yes.
Q. Number five asks for any and all correspondence and communications including e-mails between you and any other person or entity regarding Kyle Bengston.
The previous number two asked you for any correspondence and communications including e-mails between you and any attorney for Kyle Bengston. So the question I have is, are there any e-mails or correspondence between any person or entity other than the attorney for Mr. Bengston?
A. No.
Q. So the answer to number five is there's no document responsive to that request; is that correct?
A. Yes.
Q. Number six, any and all textbooks, treatises, articles, publications or other scholarly materials relied upon -- it should say by you -- in formulating your opinions in this matter.



Did you bring any such textbooks or treatises or articles?
A. Articles are in here.
Q. Okay.
A. I sent a textbook to Mr. Adams.
MR. ADAMS: The exhibit I used in my deposition of Dr. Bazemore is the one we've listed in our expert report or whatever, the disclosure. If you don't have a copy of that --
MR. WHITE: I've got a copy.
MR. ADAMS: I think the pertinent section --
MR. WHITE: Clinical Ocular Pharmacology?
MR. ADAMS: Yeah. I think the pertinent sections, or at least some of them, are photocopied in his file.
(Off-the-record discussion.)
Q. With regard to request number six, are there any other textbooks or treatises or articles



other than the textbook that we mentioned, Clinical Ocular Pharmacology, and the articles that you say are photocopied and included in Defendant's Exhibit 2 that you intend to base your opinions on in this matter?
A. There was one other textbook, and I believe the copies are in there for the information from that textbook. It was a Will's Eye Manual on Emergency Room Diagnosis and Treatment. But I am not sure that the copy of that article is in there.
Q. But other than that, you feel confident that everything that you're relying upon is included?
A. Yes.
Q. Number seven is any and all documents, photographs and materials received by you from counsel for Kyle Bengston or any other source regarding this matter.
Are all those materials included in Defendant's Exhibit 2?
A. There's one thing -- No. There is one thing in my office. It is a big file on Wal-Mart

Page 13

rules for the optometrist. It's a -- Dave copied his agreement -- the doctor's agreement between Wal-Mart and himself, and that is -- I did not bring that with me.
Q. Can you provide that to Mr. Adams to send to us, please?
A. Yes.
Q. Is that the only thing responsive to number seven that's not included in Defendant's Exhibit 2?
A. Yes.
Q. Number eight is any and all diagrams, charts, models of the eye or any other visual aid you intend to use during your testimony at trial.
Have you given any thought to what diagrams or charts or models you intend to use at trial?
A. I have. The diagrams that are included with the deposition of Dr. Bazemore are appropriate. I can use those. As far as a model, we have models of the eye and they would be good to use, but I don't have that with me.

Page 14

MR. WHITE: Dave, we would just like to see those at some point prior to trial. I don't know that he needs to ship them down here. But at some point if we could just have an agreement before we get in a courtroom we're going to be allowed to see what it is he's going to be using --
MR. ADAMS: Yeah. I will see if we can -- if he can ship them to me, and maybe I could bring them to the deposition in about two weeks. I'll see if we can do that.
MR. WHITE: That will be fine.
Q. Number nine, a list of all matters in which you have given a professional opinion in the last ten years including the names of the parties involved, the attorneys or entity that retained you, the attorney or entity representing the other party, the location of the dispute and the approximate date of your

Page 15

hire.
Do you have such a list?
A. No. I have for the past -- I've given you information on the past two years. I've given it to Dave. And that information is in this file, but not for the past ten years.
Q. Would you be able to go back to your files and recreate a list of all of the matters for which you've been retained as an expert witness?
A. I believe I have most of them, and I can create the best list possible.
Q. Does that include -- Would it include the names of the parties involved in the case?
A. Yes.
Q. Would it include the attorney who retained you?
A. Yes.
Q. And would it also include the name of the opposing counsel?
A. Yes.
Q. Can you provide that to your attorney upon your return to your office?

Page 16

A. Yes.
Q. Thank you.
Number ten is a list of all cases in which you have given a deposition in the last ten years including the names of the parties involved, the jurisdiction where the lawsuit was filed, the name of the attorney who retained you, the name of the attorney for the opposing party and the date the lawsuit was filed.
Do you have a list of depositions that you've given in the last ten years?
A. I have the depositions. I have documentation that I've given those depositions. I don't have a list. I have the information on those depositions.
Q. And from the information of those depositions, can you create such a list?
A. Yes.
Q. Will you provide that to your attorney upon returning to your office?
A. Yes.
Q. Thank you.

Page 17

Number eleven, physical copies -it should say of any and alldepositions -- you have given in the last ten yearswhich you have in your possession wherein you have rendered a professional opinion inhe area of optometry.

Did you keep any actual copies of depositions thatyou've given?

A. I believe Ihave some copies.

Q. How many such copies do you have? Do you know?

A. Approximately three.

Q. Can you provide copies of those to MrAdams so that he can provide those to us?

A. Yes.

Q. Number twelve is a list of all cases where you have testified at trial within the last ten years including the names ofhe parties involved, the jurisdiction where the lawsuit was filed, the name of the atorney who retained you and the name ofhe attorney for the opposing party and the date thelawsuit was filed.

Have you testifed at trial in the last

Page 18

ten years?

A. No.

Q. There's been no trial testimony?

A. No.

MR. ADAMS: Matt, I just want to say again that I'm completely responsible for the fact that we don't have these things -- all of these things here. It's no omission on the part of Dr. Landgraf whatsoever. It's the fault of me and my office, and we'll do what we can to satisfy the request.

MR. WHITE: That you.

Q. I've just opened up Defendant's Exhibit 2, and what I want to do is just flip through this and let you help me identify what's in this file.

The first thing I see is a pamphlet entitled Commencement 2007. What is that?

A. That is the graduation commencement pamphlet for this year's graduation at Southern College

Page 19

of Optometry where I teach.

Q. What is the purpose of that being in Mr. Bengston's file?

A. I was selected by the fourth-year class to read the optometric oath. There's information in the optometric oath that relates to keeping yourself up-to-date in terms of taking care of your patients as an optometrist.

Q. And is that something -- is the optometric oath something that's adopted by your school or is it something that's adopted by some board somewhere, or how is that -- What's the effect of the optometric oath?

A. It's read at every school's graduation.

Q. Every school's graduation?

A. Yes. Every optometry school.

Q. Is there some rule or law that requires it be read at every school's graduation?

A. I'm not aware of a rule or law.

Q. Have you ever been to UAB's graduation?

A. I have not.

Q. Do you know whether or not it's read at UAB's graduation?

Page 20

A. I'm not a hundred percent sure.

Q. The next thing I see is a photocopy of the deposition of Dr. David Bazemore, which was taken on May 15, 2007. And we're here on June 15, 2007. When was this provided to you?

A. Yesterday.

Q. Have you had a chance to read this deposition?

A. Yes.

Q. I see some handwritten notes on the front page. Are those your handwritten notes?

A. Yes.

Q. It's clipped to something else. Are these the exhibits to the deposition?

A. Yes.

Q. Then the next thing I see is a handwritten note that says at the top of it Dr. Alabata. Are those your handwritten notes?

A. Those are my handwritten notes, yes.

Q. When did you make these notes?

A. Within the past several weeks.

Q. What was the occasion for you making these notes?

A. It was per a conversation with Mr. Adams.

Page 21

Q. And then you've got several items listed below the name Dr. Alabata, and it looks like they have little stars beside them. Let me ask you about these.
It says, looks like, request gonioscopy - can we see the history of what the angle has been doing recently.
What are you talking about there?
A. Dr. Alabata discussed with Mr. Adams that gonioscopy can demonstrate what's been happening with the angle in the eye recently.
Q. When you say -- Am I reading that correctly? It says R-E-Q period. Does that mean request gonioscopy?
A. Regarding. That's a "G," R-E-G.
Q. Oh, regarding gonioscopy. Can see the history of what the angle has been doing recently.
So is that something -- This is a note that you took regarding what Mr. Adams told you about his conversation with Dr. Alabata?
A. Yes.
Q. And according to these notes, Dr. Alabata said you can see the history of what the angle has

Page 22

been doing recently if you use a gonioscopy?
A. Yes.
Q. Is that your understanding of the -- Did you have that knowledge on your own prior to Mr. Adams telling you that's what Dr. Alabata told him?
A. Yes.
Q. Your next starred item is, contact tonometry should have been used, and that's what -- Again, that's what Mr. Adams told you that Dr. Alabata told him?
A. Yes.
Q. Then you have a star by the item, Kyle Bengston's deposition. What's the significance of that?
A. I don't believe I had read Kyle Bengston's deposition.
Q. So have you read it yet?
A. No.
Q. Then you put a star by the item, amend initial report. What's the significance of that?
A. Mr. Adams discussed with me that we may need to amend the initial report that I wrote up at

Page 23

some point.
Q. Why would you need to amend your initial report?
A. In case any -- At the end of the report, it says, in case any new information comes up, we can amend it at any time.
Q. Do you have any new information right now that you wish to amend the report?
A. No.
Q. What type of new information would require you to amend your report?
A. When I wrote up the initial report, I had not reviewed -- I had not reviewed all the records and depositions and such.
Q. Tell me what you have reviewed.
A. To this date I've reviewed everything that's in that file in terms of information given to me from Mr. Adams. I've reviewed the records of the eye care rendered to the patient by Dr. Bazemore and the other eye doctors that have seen him. I have reviewed the deposition of Dr. Bazemore, and I believe that's all.
Q. Have you seen -- As far as medical records

Page 24

that you reviewed, you reviewed Dr. Bazemore's records obviously, correct?
A. Yes.
Q. Have you reviewed Dr. Sepanski's records?
A. Yes.
Q. Have you reviewed Dr. Reed Cooper's records?
A. Yes.
Q. Have you reviewed Dr. Alabata's records?
A. I reviewed the records through March of this year. I can't remember if it was Dr. Alabata's records or not.
Q. What about a Dr. Parma in Montgomery? Have you reviewed Dr. --
A. I cannot recall reviewing his records.
Q. The next item that I come to looks like a printout from a web page relating to Cogan-Reese Syndrome. Am I reading that correctly?
A. Yes.
Q. What is the significance of that?
A. Iridocorneal Endothelial Syndrome is part of the diagnosis of Cogan-Reese Syndrome, and the patient was ultimately -- One of the diagnoses

Page 25

that was considered ultimately was Iridocorneal Endothelial Syndrome.
Q. Otherwise known as ICE?
A. Yes.
Q. And that's been his ultimate diagnosis in this case?
A. It is the diagnosis that is currently the most considered.
Q. Do you agree or disagree with the diagnosis of ICE?
A. I would have to see the patient to agree or disagree. It seems -- appears correct to me. But to be a hundred percent sure, I would have to see the patient.
Q. Have you seen the patient?
A. No.
Q. You've not performed any physical examination of Mr. Bengston?
A. No.
Q. Were you familiar with the ICE Syndrome prior to becoming involved in this case?
A. Yes.
Q. The next item I have also appears to be an

Page 26

article downloaded from the Internet also pertaining to ICE; is that correct?
A. Yes.
Q. What was the reason for going on the Internet and looking up these items pertaining to ICE Syndrome?
A. To make sure that I was completely familiar with it beyond what I had learned in optometry school and subsequent to optometry school.
Q. The next item I come to is another article that looks to be downloaded from the Internet also pertaining to ICE, correct?
A. Yes.
Q. Have you been provided with Mr. Bengston's deposition?
A. I can't remember. I went through all my information in my office, and I pulled all that to bring here and it wasn't in there.
Q. If you had been provided with Mr. Bengston's deposition, do you think you would have read it prior to giving your deposition?
A. Yes.
Q. But as we sit here today, you've never read

Page 27

his deposition?
A. No.
MR. ADAMS: Matt, we will make sure he has a copy of it, and I would include that with the other things, the items I mentioned, if you wanted to do a telephone deposition subsequent to this just to ask him if he has any changes of opinion or whatever you wanted to ask him about --
MR. WHITE: We will likely do that.
MR. ADAMS: -- what he thought of Bengston's deposition.
Q. The next item I see is a letter dated May 9, 2007 from Dave Adams where he's simply forwarding the expert disclosures to you along with some other optical records of Mr. Bengston; is that correct?
A. Yes.
Q. Let me show you this. It's a letter dated March 30, 2007 from Phil Alabata, Dr. Alabata. Do you recognize that?

Page 28

A. I did read that.
Q. Who provided you with that?
A. Mr. Adams.
Q. Have you at any point corresponded with Dr. Alabata directly regarding his treatment of Mr. Bengston?
A. No.
Q. Have you talked to Dr. Alabata on the telephone?
A. No.
Q. The next item is our expert disclosures of Dr. Richard Murphy and Dr. Brett Basden; is that correct?
A. Yes.
Q. Have you read that report?
A. Yes.
Q. Do you know either Dr. Richard Murphy or Dr. Brett Basden personally?
A. No.
Q. Let me show you what this next item is. It looks to be a compilation. You tell me. It's a stapled document with a Medical Arts Eye Clinic letter on the front from Dr. Sepanski

Page 29

to Dr. Reed Cooper. Can you tell me what that is?
A. It is the records of mainly Dr. Sepanski after he had begun to see Mr. Bengston. Additionally, there are some records from Mollega Eye Care in Destin, Florida.
Q. Are those attached to each other for any particular reason or are those just all medical records you kept together in that format?
A. All medical records I've kept together in that format, the way they were given to me.
Q. This is how they arrived to you?
A. Yes.
Q. Stapled together in the corner over here?
A. Yes.
Q. The next two documents are fax transmittal forms, it looks like, where you were faxing something to Mr. Adams; is that correct?
A. Yes.
Q. Is that where you were faxing him the signed version of your expert report?
A. Yes.

Page 30

Q. And the next item is, in fact, the signed version of your expert report, correct?
A. Yes.
Q. And the next item appears to be an unsigned version of your expert report; is that correct?
A. Yes.
Q. Is that like a previous version of the report that you had printed out, or what is that?
A. I believe so.
Q. A rough draft so to speak?
A. The change we made was very minor and -- I can't recall. It had less to do with what I wrote and more to do with something else. I think they are very similar.
Q. Did you write your expert report?
A. Yes.
Q. Did you have any -- write all of it?
A. Yes.
Q. Are all of the words in your expert report your words?
A. Yes.
Q. Did you receive any help in writing your

Page 31

report?
A. I talked to Mr. Adams about what I was going to write.
Q. And did Mr. Adams give you any suggestions about things you should write or shouldn't write?
A. I think he did.
Q. Do you remember what some of those items would have been?
A. No.
Q. You don't recall?
A. No, I don't. For the most part, I wrote my report, and it was -- I had some questions regarding what I should include in terms of what I had reviewed and such, and he answered those questions. And then I included that in my report.
Q. Did you fax a version of your rough daft report down to Mr. Adams prior to executing the final version of the report?
A. I believe I did.
Q. And to your knowledge did Mr. Adams or anybody in his office make any changes to your initial

Page 32

report that did not appear in your final report?
A. It would have to compare the initial and the -- the first and the second ones that you had there, but I think the changes were more -- were minor. Grammatical some of them, perhaps.
Q. This unsigned report, let me just put that in front of you. Is that the only prior version of the report that you have?
A. I believe there were -- there was one and then I -- Yes.
Q. Yes what?
A. Yes, I believe that was the only prior report that I had.
Q. Okay. And is that saved on your computer back at your office?
A. I'm not sure.
Q. Well, let me ask you this. When you create a report, sometimes people will say, you know, report number one and save it. And when they change it, they'll say report two and save it as a new document, where some people will just

Page 33

hit "save" again and it changes the document. Do you save previous versions of your reports?
A. I didn't for this.
Q. So your testimony is that this rough draft version that we have here in front of us is the only other prior version of your report that we have?
A. Yes.
Q. The next thing I have is some more handwritten notes. Are those your handwritten notes?
A. Yes.
Q. Let me just read it to you. It says, review of new records on 5/6/07. I'll tell you what. I'm going to let you read that to me, what that is in the middle there.
A. 2/18/05 it's dated. Blur OD times 5 months. That's blur in the right eye times five months. Cleared by OD -- here I meant optometrist -- several months ago. On 2/25, that was when he saw his physician. His physician -- I believe his name is Dr. Reed -- then referred the patient to Dr. Sepanski for discomfort in the left eye. And the other

Page 34

note there is the ICE Syndrome that we previously discussed versus angle recession. These were ultimately considered in the diagnosis.
Q. So when you say at the top, review of new records, 5/6/07, would that have been the date that you first received Dr. Reed Cooper's records?
A. Yes.
Q. And you had not had a chance to review Dr. Cooper's records prior to formulating your opinions in this matter, your written opinion?
A. I believe so. I believe you're correct.
Q. You believe I'm correct?
A. Yes.
Q. You signed your written opinions on February 28, 2007. Does that refresh your recollection?
A. Yes. That's when I signed that.
Q. What is angle recession?
A. That's a form of secondary glaucoma due to trauma that one has had in one's life.
Q. Is angle recession the same thing as angle

Page 35

closure?
A. No.
Q. Tell me about recession, then. Is that a diagnosis for somebody?
A. It's a diagnosis of a type of glaucoma. Due to previous eye trauma, the angle or the drainage part of the fluid from the eye -- that's what the angle is -- can be affected to the point where the fluid doesn't drain out correctly, and the pressure can go up and cause glaucoma.
Q. But does the angle itself close all the way or close to some degree?
A. Actually it's a completely different entity. The angle on gonioscopy looks more open. Actually the iris is pulled away from the drainage area, but you have to do gonioscopy to see that that has occurred.
Q. Why is it called angle recession then? What does the word "recession" mean?
A. The iris is receding from the angle, pulling back from the angle.
Q. Why do you use the term "ICE versus angle

Page 36

recession"?
A. Mr. Adams and I were discussing ultimately what was diagnosed, and angle recession was considered by some of the ophthalmologists in some of the records.
Q. And was Mr. Bengston ever diagnosed with angle recession?
A. It was considered as part of the assessment.
Q. Did he have angle recession to your knowledge?
A. No.
Q. I've got some blank sheets of paper in there. Are those just sheets to make notes on?
A. Yes.
Q. Then I've got what looks to be Dr. Bazemore's records, correct?
A. Yes.
Q. Is that part of Dr. Bazemore's records?
A. Yes.
Q. Then you've got Dr. Reed Cooper's records, correct?
A. Yes.
Q. This next group of records looks to be a combination of Dr. Sepanski and East Alabama

Page 37

Medical Center. Will you just flip through those to confirm that?
A. I watched as you flipped through. Yes, they are.
Q. Thank you.
Next it looks like we have some photographs from Mollega Eye Care -- two pages of photographs from Mollega Eye Care, correct?
A. Yes.
Q. What is this? I'm showing you an e-mail from somebody.
A. To me this looks like an e-mail that Wal-Mart generated in relation to the lawsuit.
Q. This is not something from your office?
A. No.
Q. This is something Mr. Adams provided to you that had been provided in discovery?
MR. ADAMS: Yeah. You produced that.
Q. The next item just appears to be some kind of report generated from the court. Is there any significance to that item that I need to know about?

Page 38

A. No.
MR. ADAMS: I think I produced this to him in error actually.
MR. WHITE: Okay.
Q. The next group of records appear to be medical records from the Retina Specialists; is that correct?
A. Yes.
Q. The next group of records appear to be records from the Emerald Coast Eye Institute, correct?
A. Correct.
Q. The next group of records are from the Mollega Eye Care and Optique, correct?
A. Yes.
Q. Looks like next is some fax cover sheet to Blake Oliver here in our office, correct?
A. Yes.
Q. Next is an e-mail from Dave Adams to you requesting a copy of Dr. Bartlett's book via overnight delivery; is that correct?
A. Yes.
Q. Did you send him that book?
A. Yes.

Page 39

Q. And that's the book we talked about earlier, Clinical Ocular Pharmacology?
A. Yes.
Q. Who are those two e-mail addresses at the top? I see one is you. Who is this other one?
A. That's me also. This is my comcast address, and this is my e-mail at the college where I teach.
Q. So he sent it to both of your e-mail addresses?
A. Yes.
Q. Is this just the receipt for sending the book?
A. Yes.
Q. What is this?
A. These are initial notes I took upon my -- one of my first conversations with Mr. Adams. These were in late February. I didn't date it, but I do remember those were the initial notes.
Q. Did you take these notes prior to seeing any medical records?
A. I believe I did.

Page 40

Q. Would these notes have been taken prior to you being retained in this case, or do you know?
A. I don't know.
Q. When were you retained?
A. February 28th about. The end of February.
Q. End of February 2007?
A. Yes, sir.
Q. And so you think these notes -- handwritten notes on this small 5-by-7 piece of paper would have been taken prior to you being retained?
A. I do.
Q. Let me just go through these with you. It says "e-mail" at the top. What does that mean? Do you remember?
A. Yes. I believe it has to do with me sending him my e-mail address.
Q. And then it says, previous years, arrow, high IOPs, and you've got a star by the year 2001 and you say 38/24. IOPs meaning intraocular pressure, correct?
A. Yes.
Q. Is that what Mr. Adams told you over the

Page 41

phone?
A. Yes.
Q. Have you ever dealt with any other lawyer other than Mr. Adams on behalf of Mr. Bengston?
A. No.
Q. And the 2001 reading of 38/24, after your review of the records, do you still believe that he had an intraocular pressure in 2001 of 38 and 24?
A. That's what it said in his record.
Q. It does say that in his record?
A. Yes.
Q. And do you believe he actually had pressures that high in 2001?
A. I have to believe what's in the record, yes.
Q. In the record, isn't that scratched out and another reading entered in its place?
A. They did -- That was a reading via NCT or noncontact tonometry, and his records are hard to read. I can't say for sure if it's scratched out or not. But if you've done a test on a patient, you record it, and ...

Page 42

Q. Did you read Dr. Bazemore's deposition in regards to those readings?
A. I read that somebody in the deposition said it was 28 and 24, but it looked like 38 to me when I read it.
Q. Did you read that he went back and did the pressure test via Goldmann's?
A. I can see that in the record.
Q. And the Goldmann test was much less?
A. Yes.
Q. So for purposes of formulating your opinions in this matter, are you relying upon this 38/24 figure in 2001 as being accurate?
A. I'm relying on that as one of the pressure readings.
Q. You are?
A. Yes.
Q. Even though Dr. Bazemore has testified that it was inaccurate?
A. I have to rely on what I see in the record.
Q. Even though the doctor testified that it was inaccurate and he later did Goldmann's test that proved it to be inaccurate?

Page 43

MR. ADAMS: Object to the form. You can answer.
A. In Dr. Bazemore's deposition, he said that he used one or the other interchangeably and they both work. They are both accurate as far as he is concerned, the NCT and the Goldmann just in general.
Q. Just in general?
A. Yes.
Q. Did you also read that part of his testimony where he says often people when they first encounter the NCT will squint and that that will often raise the pressure in their eyes during that momentary point in time?
MR. ADAMS: Object to the form. You can go ahead.
A. I believe I read that in his deposition. I read the whole deposition last night, and -- It didn't take that long, but there was a lot of information in there. But it did say "squint" in the record.
Q. It did say that. But you discounted that for purposes of formulating your opinions in this

Page 44

matter?
MR. ADAMS: Object to the form. You can answer.
A. The only time that he did Goldmann tonometry was at that visit, so I have to look at the fact that he relied on NCT for all the readings when he saw the patient except for that visit.
Q. You say you have to. Why do you have to do that?
A. Because that's what he -- that's what he utilized, the NCT.
Q. He utilized the Goldmann's on this test, didn't he?
A. That's right. But he didn't at any other visit.
Q. Next you say, ophthalmologist, six months after visit, angle-closure glaucoma OD. Does that mean right eye?
A. Yes.
Q. What is the significance of that entry?
A. That was just information given to me that he was diagnosed with angle-closure glaucoma six

Page 45

months after that visit with Dr. Bazemore.
Q. And then you've got a star by the word "paragraph," and it says, opinions in terms of standard of care based upon the reviewed records, dot dot dot dot. Then you say all opinions subject to further discovery, deposition and receipt of -- I can't really read that last word.
A. Receipt of entire record.
Q. Is there another piece of paper that goes with that that we're missing?
A. I don't believe so.
Q. Is this something that you wrote down while speaking with Mr. Adams?
A. Yes.
Q. And did you in this conversation with Mr. Adams agree to become an expert -- give an expert opinion in this matter?
A. I don't remember if it was that particular conversation.
Q. Do you remember what particular conversation it was when you agreed to become an expert in this case?

Page 46

A. We had -- I had information without any -- I had information from Dr. Bazemore's records. Mr. Adams relayed information from that to me. I had no other records or information about ultimately what was diagnosed in the patient. All I had was, for example, history of haloes. There was a pressure reading that at one point was higher in one eye than the other. The patient had a little bit of reduced vision. We discussed that on the phone. And then in a later conversation I think even prior to writing this, I said to Mr. Adams, this patient was diagnosed ultimately with angle closure, right, just based on knowing what he had told me without having those records in front of me. And I said, I believe I need to look at the records to make sure that all that was in there, but then you could retain me at that point, because I could figure out that the patient had angle closure just based on that information that he had given me.
Q. Well, tell me what all information that was.

Page 47

Are you saying that based upon strictly your conversations with Mr. Adams without ever seeing any records that you were able to determine that Mr. Bengston had angle-closure glaucoma? Am I hearing you correctly?
A. That's what I supposed, but I said I would have to see the records first to confirm what he was telling me because he's not an optometrist.
Q. Tell me what information you based that on. Before ever seeing any records and based upon your conversations with Mr. Adams, how did you come to the conclusion that Mr. Bengston had angle-closure glaucoma?
A. The complaint of haloes, the fact that the patient had a problem with their vision in that eye, and the fact that there was a reading -- a difference in pressure in one eye versus the other at a previous visit, intraocular pressure reading.
Q. Difference in pressure in one eye versus the other at a previous visit?
A. Yes. So there was an asymmetry in the

Page 48

intraocular pressure. I think the most important thing was the haloes because the most important thing to rule out if a patient has haloes would be high pressure in that eye to make sure they don't have some type of glaucoma that causes high pressure. It has to be very high for them to see haloes. So the most common thing you would think of in the type of glaucoma would be angle closure.
Q. How high does the pressure need to be before you see haloes?
A. Probably about 50.
Q. When you had that conversation with Mr. Adams, you knew that something was wrong with this patient's vision by the fact that an attorney is calling you on the telephone about it, correct?
MR. ADAMS: Object to the form.
A. I think -- I believe so.
THE WITNESS: You didn't tell me to answer.
MR. ADAMS: That's fine. I was expecting you to answer.

Page 49

Q. What is this next item?
A. This was documentation that I sent the fax to Mr. Adams, and that was the fax for that report.
Q. Faxed report on 7/28/07?
A. I think it's 2/28.
Q. I'm sorry. 2/28.
Did you tell me earlier that you were retained on 2/28?
A. If I wrote a report, I was retained before then.
Q. Do you recall in this case how long in advance of writing the report that you were retained?
A. I would say that it was in the week's period of time. If not, sooner than that, if not a smaller time period.
Q. I came across another set of notes here, handwritten. Is that your handwritten notes?
A. Yes.
Q. Let's just go through these real quick. At the top you say, standard of care, and then what are you saying under that? It looks like CXS.

Page 50

A. CXS stands for complaints and exam findings. So the patient's part of -- his chief complaint was haloes around lights. Again, like before, the intraocular pressure, there was history of it being high and asymmetric. And then I was jotting notes about the tests that would be indicated based on this history and based on this intraocular pressure and then what options in terms of -- If the doctor didn't want to manage the glaucoma, they should have referred -- And actually no optometrist can appropriately manage angle-closure glaucoma because that usually requires a laser, or in this case it was a cutting procedure, trabeculectomy.
Q. When were these notes made? Do you have any recollection?
A. You know, that first week, I'm positive about that. In late February.
Q. Were these notes taken during a telephone conversation with Mr. Adams or some other time?
A. I don't recall.

Page 51

Q. These look to be some more possibly photocopies of Dr. Bazemore's records; is that correct?
A. Yes.
Q. When you got these records, did you highlight that? Did you write on the records at all or scribble or put any of your own writings on these records?
A. I don't believe I did.
Q. So when it came to you, was it already highlighted as it is now?
A. I can't remember.
Q. Do you remember writing on the records at all?
A. No.
Q. The next item is another letter -- copy of a letter from Dr. Sepanski to Dr. Cooper dated March 11, 2005, correct?
A. Yes.
Q. What is this? This is a letter from a Mr. Phillip A. Raley to a Ms. Patricia Harris regarding Pearlie Mae Scott versus Dr. Robert Hogan. What is that?
A. Mr. Adams had asked me to pull previous cases

Page 52

where I had done a deposition for the past two years, and I pulled that information. That is one of those cases.
Q. So that's why this is in your file?
A. Yes.
Q. The next letter is a letter from you to -- from you to Mr. Raley, Attorney at Law; is that correct?
A. Yes.
Q. Is that in regards to the same case?
A. Yes.
Q. Is that just correspondence you had in your file?
A. Yes.
Q. Any significance for this correspondence being in this file?
A. It allowed me to give Mr. Adams the information that was requested regarding those previous cases.
Q. What information was requested?
A. Information on the attorney that I worked with where I had done a deposition for prior cases, the other attorney that was involved with the

Page 53

case, the name of the patient, the name of the doctor.
Q. Then there's another letter from you to Mr. Raley. It looks to be some time records that you sent to him or a bill perhaps; is that correct?
A. Yes.
Q. And then there's some notes down here on the bottom, sticky notes. What is that?
A. These were notes I made in regards to a phone call from Mr. Adams.
Q. Were those some of the things he was asking for from you?
A. Yes.
Q. So he asked you for a list of exhibits. Is that a list of exhibits you used in that case?
A. No. This would be a list of exhibits I would use in this case.
Q. It says e-mail. Did he want you to e-mail him the list of exhibits?
A. I believe so.
Q. And then it says general. What does "general" mean?

Page 54

A. In general what are the textbooks and articles that I would be using in terms of this case.
Q. It says, depositions over past four years. Did you provide him with that?
A. I did.
Q. And then name of case in middle district, what does that mean?
A. The information that he wanted regarding each of those cases, where I did the deposition. I think he wanted some information regarding to a legal term called "middle district" or what district the case was in.
Q. Have you been an expert in a case in the middle district of Alabama before?
A. No.
Q. Never have?
A. No.
Q. Well, you've never been an expert in any case at a trial as far as you know --
A. Yes.
Q. -- regardless of where it was at trial.
A. Yes.
Q. What is this last entry, VS and case number?

Page 55

A. VS stands for versus, like in this case it would be Bazemore versus Bengston. So this would be for the previous cases, though, and if there was a case number assigned.
Q. And did you provide all that information?
A. I did.
Q. The next document is one entitled -- it says "affidavit" at the top. What is that?
A. This is in relation to one of the cases that I did that Mr. Adams required information on. This is the case Mr. Raley was the attorney that we discussed before.
Q. Next you have, it looks to be, another unsigned copy of your expert report in this matter; is that correct?
A. Yes.
Q. And then that's followed by a fax report. Is that a report verifying that a fax went out?
A. Yes.
Q. What's the date of that fax?
A. That one says April 10. I'm looking for the date -- Yeah.
Q. The last thing that appears in here looks to

Page 56

be a fax cover sheet to David Adams from you, and it says, here is the information from the clinical text, Clinical Ocular Pharmacology, referenced in the report. I know this information is not easy for the layman to understand, but I will reference this text passage in our discussion, Tom. And you've attached what looks to be an excerpt from that textbook; is that correct?
A. Yes.
MR. WHITE: Let's take a break.
(Brief recess.)
(Defendant's Exhibit 3 marked for identification.)
Q. (Continuing by Mr. White) Doctor, I want to ask you some questions about your educational background, and I'm going to show you what's marked as Defendant's Exhibit 3. This is your expert witness disclosure. And attached to that is your CV, and I just want you to confirm that for me.
A. Yes.
Q. Is that your most recent version of your CV?

Page 57

A. As of March of this year.
Q. As of March?
A. Yes.
Q. Has something changed since March that you need to add to that?
A. I was Teacher of the Year again and read the optometric oath at graduation. Those are both honors. I've done several continuing education courses since March.
Q. You say you've done. Have you taught them or attended them?
A. Taught them.
Q. What courses have you taught since March?
A. I taught a course on cases -- just general optometric cases and a course on allergies in Memphis in April. And I taught a course on injections for the Illinois College of Optometry in Chicago to their faculty and students. It was an elective course.
Q. Where are you from originally? Where did you grow up?
A. Chicago.
Q. You graduated high school in Chicago?

Page 58

A. A suburb, St. Charles High School.
Q. Where did you go to undergrad?
A. Ripon College, R-I-P-O-N, in Wisconsin.
Q. What was your course of study in Ripon College?
A. Chemistry and biology.
Q. Where is Ripon located?
A. Ripon, Wisconsin.
Q. And what was your degree in?
A. It was a B. A. in biology with a minor in chemistry.
Q. Do you remember what your overall GPA was upon graduating from Ripon?
A. 3.15.
Q. Did you have any honors or anything that you graduated with?
A. I don't recall. I think I was in Beta Beta Beta, which is the biologic honor society.
Q. What year did you graduate from Ripon?
A. 1984.
Q. What did you do upon leaving Ripon College?
A. I started Illinois College of Optometry the following fall.

Page 59

Q. Where is that located?
A. Chicago.
Q. How long did you attend Illinois College of Optometry?
A. Four years.
Q. Did you graduate with honors or anything of that nature?
A. Yes.
Q. What is that?
A. Magna Cum Laude. I think my GPA was 3.70.
Q. You think it was 3.70?
A. At least, yes.
Q. What does Magna Cum Laude mean?
A. I think you have to get above a 3.6 to get that at Illinois College of Optometry.
Q. Is it different for different schools?
A. Yes.
Q. I notice that your CV says Cum Laude. Is there a difference between Cum Laude and Magna Cum Laude?
A. I guess I was Cum Laude. That's my mistake.
Q. What's the difference between Cum Laude and Magna Cum Laude?

Page 60

A. At Illinois College of Optometry, I can't recall. It has to do with your GPA. Maybe Magna was 3.75. I can't recall.
Q. What was your class rank? Do you know?
A. I would say it was in the top 15 out of approximately 120 students.
Q. And you graduated from there in 1988?
A. Yes.
Q. And then you did a residency in primary care at The Eye Institute at the Pennsylvania College of Optometry; is that correct?
A. Yes.
Q. What is a residency in primary care?
A. It is an optometric residency geared at all types of optometry within a year. It's a structured program to make sure that you are tops in the field. Approximately 10 percent of optometrists do residency. It would be similar to a residency you would hear in other fields except it's just for a year.
Q. And you said not all optometrists do that?
A. Approximately 10 to 15 percent.
Q. How many optometry schools are there in the

Page 61

United States?
A. There's about 20.
Q. And do you have an opinion as to where your school, the Illinois College of Optometry, ranks as far as optometry schools in the United States?
A. No.
Q. Do you have an opinion as to where the UAB optometry school ranks as far as optometry schools in the United States?
A. No. They are both accredited, and I've worked with -- I have had experience at ICO. I know that it's a good school, and I know that UAB is, too, based on my interactions when I've been there for things.
Q. You don't have an opinion as to one school being better than the other?
A. No. I think they are both very good schools.
Q. Where are you licensed to practice optometry?
A. In Tennessee.
Q. Are you licensed in any other states?
A. Not currently. I have -- I forgot the term. I've had a license in Illinois and

Page 62

Pennsylvania, but they are inactive at this time.
Q. When did you -- First of all, when did you first become licensed in Tennessee?
A. 1996.
Q. When did you first become licensed in any state to practice optometry?
A. 1988.
Q. And where was that?
A. Pennsylvania.
Q. And then when did you become licensed in Illinois?
A. 1989.
Q. Is there any reason why you are no longer active in or actively licensed in Pennsylvania or Illinois?
A. Because I don't live there.
Q. Is that the only reason?
A. Yeah.
Q. Are you licensed in Alabama?
A. No.
Q. Have you ever been licensed in Alabama?
A. No.

Page 63

Q. Have you ever applied for a temporary license to practice in Alabama?
A. No.
Q. How many times have you given a professional opinion in a case arising out of Alabama?
A. I can't recall any times so that would be zero.
Q. So this case would be the only time that you've rendered a professional opinion in a case arising out of Alabama?
A. Yes.
Q. Are you familiar with or friends with any particular optometrist in Alabama?
A. I know of optometrists in Alabama because I've done -- I've served as an examiner for the national boards in Birmingham at that college on at least three or four occasions. So I've seen their graduates take their clinical exams for national boards.
Q. But are you close professional acquaintances with any particular Alabama optometrist?
A. I know Dr. Martha Greenburg. She was a board of trustee member at Southern College Of

Page 64

Optometry.
Q. Who is she?
A. She's an optometrist in Florence, Alabama.
Q. Anybody else?
A. No.
Q. So after completing your residency, what did you do?
A. I taught in Chicago at Illinois College of Optometry.
Q. And it looks from your resume or CV that you've been in -- been teaching pretty much your whole career. Is that fair to say?
MR. ADAMS: Object to the form. Go ahead.
A. I've worked in practices, too, throughout my career. It's always been one day a week when I did that.
Q. You say you've worked in practices. Tell me what practices you've worked in.
A. Southern Eye Associates in Memphis, which is a referral center.
Q. First of all, I want you to tell me every practice you've worked in. You told me

Page 65

Southern Eye Associates. Anywhere else?
A. I'm trying to think. Like if an optometrist, for example, at a Wal-Mart or a -- needs help -- I'm trying to think of the other location. If I know them and they need help for a day, I have subbed for them probably about ten times over the 15 years that I have been in Memphis. LensCrafters would be in that ten times.
Q. You're talking about LensCrafters and Wal-Marts and places like that?
A. For a day when an optometrist was in a bind and they needed help that day and I knew them.
MR. ADAMS: I'm going to object to the form. I don't think he's ever testified that he ever worked at a Wal-Mart, but if he has -- I was just objecting to the form.
Q. I'm sorry. I didn't mean to put words in your mouth. Have you ever worked at a Wal-Mart store?
A. I worked for the optometrist that worked

Page 66

there. I subbed for her one day.
Q. How many times have you done that?
A. Probably about three or four times in the 15 years that I've been in Memphis.
Q. What's that lady's name that works at Wal-Mart?
A. Rhonda Baltier.
Q. Could you spell her last name, please?
A. Sure. B-A-L-T-I-E-R.
Q. What Wal-Mart location is that in Memphis?
A. I believe it's in Cordova, C-O-R-D-O-V-A.
Q. Is that in Tennessee or Mississippi?
A. Tennessee.
Q. So you said something about Southern Eye Associates being a referral center. What did you mean by that?
A. Optometrists would send patients there for second opinions. There's an ophthalmologist there and an optometrist.
Q. And why would optometrists send patients there for second opinions?
A. If they needed, for example, a consult on a patient that they were having difficulties

Page 67

managing for consultation, they would send patients -- Since there was an ophthalmologist there, they would send them for cataract surgery also.
Q. And how often did you work at Southern Eye Associates?
A. I worked there for six months one day a week.
Q. What years did you work there?
A. I don't remember the year. It was around 2000, I believe.
Q. Is that place still in business?
A. Yes, sir.
Q. And what part of Memphis is it located in?
A. It's in east Memphis.
Q. And did they see patients just off the street who need glasses or think they may need glasses?
A. Southern Eye Associates?
Q. Yes.
A. They see patients that are referred in to them more likely from the community.
Q. So it's not just like an optometry shop where people make appointments to get their eyes

Page 68

examined?
A. No.
Q. Other than the work at Southern Eye Associates and the filling in for people for approximately ten times in 15 years, have you ever worked at any private optometry practice?
A. No.
Q. Tell me what you do on a daily basis where you work.
A. I see patients in the ocular disease service with students. I do that four days a week. I provide complete eye care to the patients. For example, I see patients with glaucoma on a regular basis. They are seen every three months, but I also do all their other eye care. If they need glasses, then I do that, if they need -- whatever they need related to their eyes. Even though I see patients with eye disease, I take care of the patient.
Q. What is the name of the facility where you work at?
A. The Eye Center at Southern College of Optometry.

Page 69

Q. How do patients come to see or come to be at The Eye Center at Southern College of Optometry?
A. Through word of mouth.
Q. Is it open to the public?
A. Yes.
Q. Is it a referral center such as Southern Eye Associates?
A. No.
Q. Do y'all see people who come in off the street who may need glasses or think they may need glasses?
A. Yes.
Q. Do you do that type of work also?
A. Yes.
Q. How long have y'all been -- have you been working at The Eye Center at the Southern College of Optometry?
A. For 15 years.
Q. How are you paid?
A. Every two weeks.
Q. Are you paid a salary?
A. Yes.

Page 70

Q. How much do you make at The Eye Center?
A. I think it's about $96,000 a year currently.
Q. And is your pay in any way based upon the profits or the income made by The Eye Center?
A. No.
Q. What is your title at The Eye Center at Southern College of Optometry?
A. I'm a professor.
Q. Did you say you worked there four days a week?
A. I work there five days a week. I see patients four days a week.
Q. On the days that you see patients, how many hours a day are you seeing patients?
A. Six.
Q. Six hours a day?
A. Yes.
Q. What do you do on the fifth day?
A. That is my development time as a faculty member to prepare lectures, for example.
Q. Do you --
A. Keep up-to-date on journals and such.
Q. Do you teach courses?
A. At the college?

Page 71

Q. Yes.
A. Not currently. I'm going to teach a course in the fall.
Q. When you're teaching courses, do you still maintain the same schedule at the eye clinic?
A. Give or take a few hours.
Q. When you're working at the eye clinic, are you working along with students? Do you have students there by your side who you are teaching in that process?
A. Yes.
Q. Is that always the case or is it sometimes it's just you and the patient or are you always meeting with the patient along with the student?
A. I'm always meeting with the patient along with the student.
Q. How many students will you -- When you're meeting with the patient, how many students will also be there with you?
A. Per patient?
Q. Yes.
A. Two at the most. One or two.

Page 72

Q. Not more than two?
A. No. If there's something really interesting on a patient and I want the students to see that, then I would ask the patient if that's okay and bring the students in to see that additional.
Q. And how do the patients pay at the eye clinic? Do y'all charge just like any other eye clinic would?
A. I believe so. We see a lot of PEN Care patients so that's insurance based. We see a lot of Medicare patients, and we see self-pay patients.
Q. Do y'all have any particular missi on there that you're designed to care for certain types of income brackets as opposed to others or anything of that nature?
A. The mission of the college is to educate students on the art and science of optometry.
Q. But as far as your clinic goes, you're not catering to one particular clientele or the other?
A. No.

Page 73

Q. You're not trying to get in a certain sector of the population?
A. No. We're trying to get in as many patients as possible from a variety of sectors.
Q. Does your clinic advertise in the local Yellow Pages?
A. Yes.
Q. Do you advertise on radio and TV?
A. Yes.
Q. Do other optometrists also work there at the clinic?
A. Yes.
Q. How many other optometrists are there at the clinic?
A. Approximately 45.
(Brief interruption.)
MR. ADAMS: Can you break that question down about radio and TV?
Q. The eye clinic where you work at, do you advertise on the radio?
A. Yes.
Q. And do you also advertise on TV?

Page 74

A. Yes.
Q. And we got interrupted there, but how many other optometrists work there at the clinic?
A. Approximately 45.
Q. How many patients does the clinic see on a daily basis on average?
A. That's hard for me to answer. The clinic that I work in, which is the ocular disease service, we see approximately 35 patients per day. The entire clinic, several hundred.
Q. When you say you work at the ocular disease -- What did you call it? Ocular disease portion or section? What is that?
A. There are different sections of the clinic. The advanced care ocular disease service sees patients with ocular disease.
Q. How do you know that they have ocular disease? How are they routed to you?
A. From the primary care service traditionally. We have a regular eye service for routine eye exams. Then if they have glaucoma or diabetic retinopathy or macular degeneration or an eye disease problem, they are sent to the ocular disease clinic, and then we'll see them on a chronic basis. I've accumulated patients over years because I've been there 15 years, and I've been seeing patients from 14 or 15 years ago for glaucoma. And you accumulate patients that way just like a practice.
Q. But when they are sent to you, they already have some chronic problem that you're treating them for; is that fair?
A. Most of the patients. I mean, we see walk-ins and emergencies, like if somebody has a red eye or decreased vision.
Q. Would you see them in the ocular disease section?
A. For walk-ins and emergencies, we would.
Q. What is the primary care section?
A. If you would call and say I want a regular eye exam for glasses.
Q. And did you work in the primary care section of that clinic?
A. Yes.
Q. How long did you work in the primary care section?

Page 75

Page 76

A. Approximately ten years.
Q. And then how long have you been in the ocular disease section?
A. I would say 15 years. You can work in the primary care service and the ocular disease service on a different day. But I work only in the ocular disease service currently.
Q. How long has it been that you've worked only in the ocular disease section?
A. Approximately five years.
Q. So is it fair to say, then, in the last five years you don't do routine eye exams on a daily basis?
A. Remember I told you that my patients don't go back to the primary care clinic, the patients that I see chronically for their routine eye care, because once I'm their doctor, I'm their doctor. Don't -- Patients don't want to see another doctor to be sent back to primary care to figure out their glasses. So I do that with all my chronic care patients.
Q. But any patient that you see for glasses is already under your treatment for chronic care;

Page 77

is that correct?
A. For the most part, yes.
Q. Is it fair to say, then, that over the last five years you have not seen patients for a routine eye exam who are not already under your care for chronic problems?
A. Not really, because if a patient comes to the clinic and they are complaining about blurry vision and it was sudden and they get up to my clinic and it really wasn't sudden and they really want a regular eye exam, I do it. I don't send it to somebody else.
Q. How often does that happen?
A. Maybe about 10 percent of the time at most.
Q. Let me ask you about your expert services. How long have you been in the business, so to speak, of providing expert services? How long have you been doing that?
A. About ten years.
Q. And currently what percentage of your income is derived from expert services?
A. Three to five percent.
Q. Does your employment with the college allow

Page 78

you to serve as an expert in outside matters?
A. Yes.
Q. Does the money that you make in your expert services go to you individually or does that go to the university or the college?
A. It goes to me. For example, I took two vacation days off to come here. That's not something that I'm given time for from the college.
Q. Do you advertise your expert services in any way?
A. No.
Q. How do people learn of you? Do you know?
A. Word of mouth.
Q. Are you listed in any professional journals or expert listing services that you know of?
A. No.
Q. Do you pay any fees to be listed in any expert witness listing services or anything of that nature?
A. No.
Q. Do you know as we sit here today how many times that you have been retained as an expert

Page 79

witness?
A. Approximately 15.
Q. And of those 15 times, do you know what percentage of those times you were retained on behalf of the plaintiff and what percentage you were retained on behalf of a defendant?
A. I would say it's 60 percent for the plaintiff and 40 percent for the defendant. I want to make sure that I get that correct.
MR. ADAMS: Plaintiff is the one bringing the lawsuit and the defendant is the one being sued.
THE WITNESS: What I'm doing in this case is on behalf of the plaintiff?
MR. ADAMS: Yes.
A. Then I am correct. Sixty percent.
Q. Of the 15 times you've been retained as an expert witness, do you recall on how many of those occasions the issue has been a misdiagnosis of glaucoma or a failure to diagnose glaucoma?
A. Two.

Page 80

Q. Two?
A. (Witness nods head positively.)
Q. Do you recall the names of those cases?
A. I've been asked this before. One was for a case in Arkansas, and it was a long time ago and I could not find the documents for it before. It wasn't for that other case that we talked about.
Q. So one you can't remember?
A. One I really can't remember, and I would have to look through my files to figure out the other one.
Q. Do you think you could figure that out after looking through your files?
A. Yes.
Q. And do you remember generally what the issues were in those two cases?
A. The one from northeast Arkansas involved an optometrist that did not diagnose glaucoma.
Q. Did not diagnose it?
A. Yes.
Q. And did you testify on behalf of the doctor or the patient in that case?

Page 81

A. I testified on behalf of the doctor.
Q. And what did you say on behalf of the doctor in that case? What was your opinion on behalf of the doctor?
A. That it was open-angle glaucoma and that it was difficult to predict how quickly the damage occurred in this type of glaucoma for the patient.
Q. Is that the case where you can't remember the names of the parties?
A. Yes.
Q. Is that something that you would be able to go back and determine from looking at your notes and records?
A. I really looked hard the last time, but I could look again.
Q. You said it was in northeast Arkansas?
A. Yes.
Q. Do you remember what county in northeast Arkansas it was in?
A. It might have been Mississippi County.
Q. Do you remember -- I may have already asked you this. Do you remember either of the

Page 82

parties' names?
A. I don't.
Q. Parties meaning -- Like you don't remember the doctor's name who you testified on his behalf?
A. No. It was at least eight years ago, if not longer.
Q. And you don't remember the person's name who was suing the doctor?
A. No.
Q. Do you remember either of the attorneys' names who were on either side?
A. No. And I did not do a deposition for that case. I do remember that.
Q. And you can't find your opinion that you rendered in that matter?
A. No.
Q. What was the other case that you testified regarding glaucoma?
A. I can't recall. I'm estimating one or two cases. I really can't -- I'm almost doing that just to make sure just in case I had another one, but I can't remember one. That's the only one I can really remember regarding

Page 83

glaucoma.
Q. How many times total have you given a deposition?
A. About six times.
Q. When you go back and review your records and notes, are you going to be able to determine how many -- in what cases you gave those depositions?
A. Yes.
Q. So if I have an opportunity to speak with you again, you can provide me with the names of those cases?
A. I will look for every case that I've done in the past, yes.
Q. Let me just go back and make sure I understand what you just told me about cases involving glaucoma. You told me about one case in northeast Arkansas where you testified on behalf of a doctor, and in that case the issue was open-angle glaucoma; is that correct?
A. Yes.
Q. And then you said you think there was at least one other occasion where you testified in a

Page 84

case involving glaucoma, but you can't recall what that is at this time?
A. Right.
MR. ADAMS: I'm going to object to the form. I may have missed the question, but if you asked him did he testify for that doctor, I believe his prior testimony was that he never testified.
MR. WHITE: You're correct. I'm sorry. I didn't mean to misstate that.
Q. You told me you were retained on behalf of the doctor but you never testified in the northeast Arkansas case.
A. Yes.
Q. I'm sorry. I didn't mean to misstate that.
And then there was one other case you believe involving glaucoma, but you don't remember the name of the case?
A. I don't, and I don't do these enough to know -- Some years I don't do one, and one year I'll do two. I don't do them enough that

Page 85

I can remember.
Q. Do you remember in that other case whether you represented the doctor or whether you represented the individual suing the doctor?
A. I don't remember.
Q. Have you ever offered an opinion or testified in any other case regarding the use of noncontact tonometry?
A. No.
Q. Have you ever testified or given an opinion in another case regarding the use or failure to use Goldmann's tonometry?
A. No.
Q. Have you ever testified in another case or rendered an opinion in another case regarding the use of or failure to use gonioscopy?
A. No.
(Brief off-the-record discussion followed by a brief recess.)
Q. (Continuing by Mr. White) I asked you earlier about -- when we were going through your notes here in Defendant's Exhibit 2 about first being retained. Just so I'm clear, is it your

Page 86

testimony that you were first retained in this case within the two or three weeks immediately proceeding your giving an opinion in this case?
A. Yes.
Q. And that contact would have been through Mr. David Adams; is that correct?
A. Yes.
Q. You were not contacted by anyone else on behalf of the plaintiff, correct?
A. No.
Q. And during the course of our going through your notes in Exhibit 2, did we talk about all the conversations you had with Mr. Adams prior to rendering your opinion in this matter?
A. Yes.
Q. Did you ever have a letter of engagement -- an official letter of engagement from Mr. Adams to you where he retained you?
A. No, not that I'm aware of.
Q. How did you make him aware of your fees and expenses and things of that nature?
A. I verbally told him.

Page 87

Q. You didn't send him any kind of contract for him to sign or anything of that nature?
A. No. I may have sent him an e-mail regarding my fees, but it wasn't a contract. I believe I verbally told him.
Q. I believe I asked you earlier whether you ever treated the plaintiff or saw the plaintiff. Have you ever met the plaintiff --
A. No.
Q. -- Mr. Bengston?
A. No.
Q. And other than reviewing his medical records, have you ever seen any other photographs of him?
A. No.
Q. Have you corresponded with him in any way?
A. No.
Q. Have you ever talked to Mr. Bengston on the telephone?
A. No.
(Brief lunch recess.)
Q. (Continuing by Mr. White) I want to ask you specifically about glaucoma. First of all,

Page 88

can you just tell me in your own words what is glaucoma?
A. It's an eye disease where it's believed that high pressure damages the eye nerve, which results in visual field loss and can result ultimately in blindness.
Q. What causes the high pressure?
A. For the most common type of glaucoma, it's probably genetic. That has something to do with it.
Q. What's the most common type of glaucoma?
A. Open angle. With open angle there's a genetic component to that. But there could be anatomical problems with other types of glaucoma that cause the pressure to be high.
Q. What causes narrow-angle or closed-angle glaucoma?
A. There's a structure in the eye that can only be observed like with a gonioscopy lens that's called the angle. It's basically where the fluid drains out. There's a fluid in the eye, and it drains out of the eye compartment through the angle. It's a filtering

Page 89

mechanism.
Q. What causes that angle to close?
A. People are predisposed to it. Some of us are born with narrow angles.
Q. What else?
A. You could have secondary types of closed angle. You could have new blood vessels form there in patients that have diabetes, for example.
Q. What else can cause secondary?
A. You can have a lot of inflammation present in that angle.
Q. Anything else?
A. There's lots of causes. Those are probably the main ones.
Q. Trauma? Can trauma be a cause of secondary angle-closure glaucoma?
A. Not angle disclosure but a secondary type of glaucoma.
Q. What type of glaucoma would trauma --
A. Angle recession. But the angle is not closed. It's just not functioning correctly to drain out the fluid.

Page 90

Q. Tell me, what are some of the risk factors for glaucoma?
A. Being African-American, age, cardiovascular disease, thinner than normal corneas, increased intraocular pressure. Those are all for -- We're thinking of open-angle glaucoma with those.
Q. What about for secondary angle-closure glaucoma? What are --
A. Diabetes.
Q. -- the risk factors?
MR. ADAMS: Make sure he finishes his question because she's got to get everything down. And if y'all talk at the same time, it makes her job harder.
Q. Do you remember the question?
A. Retinal vascular disease.
Q. Anything else?
A. You asked about secondary --
Q. Secondary --
A. -- angle-closure glaucoma?
Q. Yes, sir.

Page 91

A. Inflammation.
Q. Due to what?
A. Well, one example would be ICE.
Q. Anything else?
A. That sums up the main causes. There's primary angle-closure glaucoma too.
Q. Did Mr. Bengston have primary angle-closure glaucoma?
A. It looks like he had secondary angle-closure glaucoma.
Q. Secondary, doesn't that mean due to something else?
A. Right. In this case it was due to an anatomical problem with his angle. Inflammation was present.
Q. Are you referring to the ICE Syndrome?
A. Yes.
Q. Let me go back to some of these risk factors you just talked about. African-Americans are more disposed to develop glaucoma; is that correct?
A. All the risk factors -- Yes. Open-angle glaucoma. All the -- You asked risk factors

Page 92

for glaucoma and open angle -- those are all the risk factors for open-angle glaucoma.
Q. When you say age, I presume you mean the older you are, the more inclined you are to develop glaucoma.
A. Yes.
Q. And is there some magic age where it becomes -- you become much more at risk to develop glaucoma?
A. For open-angle glaucoma, we're concerned about anyone over the age of 55 and really concerned about patients over the age of 75.
Q. Does that change with closed-angle glaucoma? Is there a certain risk factor for age as far as closed-angle glaucoma?
A. The primary closed-angle glaucoma, the risk is with age. It has to do with your prescription in your glasses. If you're hyperopic, it puts you more at risk for primary angle-closure glaucoma.
Q. What is hyperopic?
A. It means you're farsighted.
Q. Do you know if Mr. Bengston was farsighted?

Page 93

A. No, he wasn't. But he had secondary angle-closure glaucoma.
Q. That's what I was asking you.
A. Okay.
Q. You were differentiating, it seems to me, between the risk factors for open-angle glaucoma and closed-angle glaucoma; am I correct?
A. Yes. And there are different types of closed-angle glaucoma, and most of those types have specific age groups and risk factors associated with them. For example, ICE tends to occur in younger individuals under the age of 40. It tends to occur in only one eye.
Q. What causes ICE?
A. The biggest problem is a genetic problem that predisposes them to inflammation in the angle.
Q. Genetic meaning you're born with it?
A. Yes.
Q. And occurs --
A. Tends to show up in patients young adults and onward.
Q. Did you say earlier 40 years old and less?

Page 94

A. Yes. That's when it tends to show up.
Q. But the fact of the matter is if you have it, you have it from the time you're born?
A. I think you're predisposed to it, and the manifestations of it don't show up until later in life.
Q. What are the symptoms of ICE?
A. The symptoms of angle closed are going to be the same for all those types that I mentioned. So the symptoms for ICE would be seeing haloes around lights, eye pain, eye redness, blurry vision, nausea, vomiting.
Q. Would the nausea and vomiting be related to the increased IOP, intraocular pressure?
A. Yes.
Q. Any other symptoms for ICE?
A. Eventually if it's not treated, then they are going to lose their side vision and they are going to go blind.
Q. Tell me again what the acronym ICE stands for.
A. Iridocorneal Endothelial Syndrome.
Q. Is ICE a rare syndrome?

Page 95

A. Yes.
Q. How rare is it?
A. Very rare.
Q. How rare is very rare? Do you have any statistics to tell us how rare it is?
A. No.
Q. Have you ever had the occasion in your career as an optometrist to treat a patient with ICE Syndrome?
A. No.
MR. ADAMS: Let me just kind of issue a blanket objection to questions related to the ICE Syndrome. That is something that as an eye disease I think the treating ophthalmologist will be presenting evidence on. Just a blanket objection. Go ahead.
Q. How do you diagnose ICE Syndrome? Do you know?
A. You would base it on looking at the cornea, base it on measuring the intraocular pressure, base it on the gonioscopic view of the angle,

Page 96

and then that accompanied by the risk factors that the patient has if they fall into that risk factor group.
Q. How would you differentiate glaucoma from ICE Syndrome? What's the difference?
A. What kind of glaucoma, open angle?
Q. Closed-angle glaucoma.
A. The symptoms would be the same. The gonioscopic view would help you make that diagnosis.
Q. What would you see in the gonioscopic view that would determine it was ICE Syndrome as opposed to closed-angle glaucoma?
A. One of the things you would see would be peripheral anterior synechia.
Q. What is that?
A. They are little adhesions between the iris and the angle, and they are indicative of inflammation in the angle.
Q. How do you treat ICE Syndrome?
A. You need to lower the pressure. You can do that with medications. If that doesn't work, then a glaucoma surgery would be done.

Page 97

Q. So is ICE Syndrome caused by glaucoma?
A. I would say ICE Syndrome causes glaucoma.
Q. So you have ICE Syndrome first and it, in turn, causes the glaucoma?
A. Yes.
Q. As far as the ICE Syndrome is concerned, does it cause any other problems with the eye other than what's known as glaucoma?
A. Because the pressure goes up and there's a problem with the cornea, the cornea can become swollen.
Q. Call it corneal edema?
A. Yes. Part of the syndrome is irido -- this stands for iris -- so they end up with problems with their iris too.
Q. What kind of problems do they have with their iris?
A. There may be lack of pigment in the iris that can actually develop into a hole in the iris, and I think one of the photos has an iris defect on it.
Q. What causes the hole in the iris?
A. Now you're getting -- I haven't seen -- I

Page 98

think it's a congenital problem that contributes to that. There's a genetic propensity to lose pigment. And so if you lose enough -- your iris is mainly composed of pigment -- you're eventually going to have a hole through it.
Q. When you say congenital component, what do you mean by that?
A. When I say congenital, I mean genetic.
Q. Is it common for a 20-year-old white male to have glaucoma?
MR. ADAMS: Object to the form.
A. It's not common.
Q. What percentage of the population in general -- Let's just say the population of the United States. What percentage of that population has glaucoma?
A. For every age? I would say about 2 percent.
Q. And if you take the -- Let me just, for purposes of this next question, take the universe of people in the United States who have glaucoma. That's who I'm talking about here. Let me ask you a question about that

Page 99

subset of people.
What percentage of those people are young white males -- young meaning 20 to 25 years old -- with no family history of glaucoma and no trauma to the eye and no health issues, meaning they are not diabetic? Could you give me an idea of what percentage of the glaucoma population that would encompass?
A. Less than 1 percent.
Q. Meaning less than 1 percent of that entire population of glaucoma patients; am I correct?
A. I'm not sure if I understand.
Q. The population -- If you had the entire population of glaucoma patients being a new 100 percent of patients, then is it your testimony that that subset of young white males with no family history of glaucoma, no trauma to the eye and no health issues would be less than 1 percent of that 100 percent figure?
A. Yes.

Page 100

Q. Is angle-closure glaucoma an acute condition?
A. It can be.
Q. Are you familiar with the term "acute angle-closure glaucoma"?
A. Yes.
Q. And when used in that context, what does the word "acute" mean?
A. The patient is suffering an angle closure attack at that time.
Q. And how quickly can an acute-angle closure glaucoma develop?
A. Within hours.
Q. So, for instance, if you had a person who had an eye pressure of 13, for instance, and later had an angle closure attack and his pressure elevated, how quickly could you go from 13 to a much higher pressure?
A. Within hours.
Q. To your knowledge did Mr. Bengston suffer from acute angle-closure glaucoma?
A. Not at the -- No.
Q. Do you recall whether he was ever diagnosed with acute angle-closure glaucoma?

Page 101

A. I think he was diagnosed with intermittent angle-closure glaucoma.
Q. Who diagnosed that? Do you recall?
A. I believe they wrote angle-closure glaucoma, Dr. Sepanski. But based on the records and based on -- it looks like it was -- it was acute at the time that he saw the patient.
Q. It was acute at the time he saw Sepanski?
A. Yes. The pressure was 52.
Q. It was acute at the time Bengston first saw Sepanski. Is that what you're saying?
A. Yes.
Q. And the pressure was 52 on that occasion?
A. Yes.
Q. If a patient presented to you with acute angle-closure glaucoma, what would you expect to see in that patient's eye?
A. I would expect via gonioscopy that the angle was narrow or closed. I would expect the pressure to be elevated. Those would be the main signs that I would see. The cornea may be cloudy or swollen.
Q. Would you expect any other symptoms in the

Page 102

patient?
A. I would expect the patient to say that they had problems with their vision, that they were seeing haloes, that they may have pain in their eye.
Q. Would they complain of -- In a situation of acute angle-closure glaucoma, would they complain of nausea or vomiting?
A. They may. That's listed as symptoms of it in textbooks. Most patients that I've seen with angle-closure glaucoma that was acute did not have nausea or vomiting.
Q. Would they have severe pain in their eye?
A. No, not severe. Their symptomatology varies so it's important that -- the signs I see are just as important as the symptoms. There are certain symptoms that are indicative of a serious -- possible serious problem with glaucoma that don't occur with a lot of other things.
Q. Such as what?
A. The haloes.
Q. Tell me what you mean by that.

Page 103

A. I rarely see patients that report to me that they see haloes around lights. That means there is a problem with their cornea, and I would say it's from the pressure being elevated 99 percent of the time.
Q. So you rarely see patients who complain of haloes around lights?
A. Right. But I know it's a serious complaint because it usually or almost always indicates that there's a problem with the cornea, and usually that comes from the cornea being swollen secondary to increased intraocular pressure. So it's a red flag for me that something serious may be going on.
Q. What are some of the causes of haloes around lights?
A. Anything that can cause the cornea to be swollen.
Q. Isn't that what it is a symptom of, the cornea being swollen?
A. The haloes come --
(Brief interruption.)
Q. Do you remember my question?

Page 104

A. Symptoms -- Can you repeat it, please?
Q. Isn't the complaint of seeing haloes around lights really a symptom of the cornea being swollen?
A. Yes.
Q. And there are various different things that cause the cornea to become swollen, correct?
A. Yes.
Q. Tell me what some of those various different things are.
A. Mild corneal swelling can come from problems with the endothelium in the cornea, which is the back part of the cornea. That would cause mild swelling. They might complain about a little bit of blur, but I doubt they would see haloes. Severe corneal swelling, again, the most common reason for that would be high intraocular pressure, because the fluid presses so hard on the back of the cornea that it can damage the endothelium and affect it from working. The back of the cornea works to pump fluid out or water out of it. And if you've got pressure that's pushing on the

Page 105

endothelium, it can't get the fluid out of the cornea. So then the patient gets severe edema, and they start to see haloes around lights.
Q. Do you treat many patients who wear contact lenses?
A. Yes.
Q. Do patients who wear contact lenses and who suffer from dry eyes often complain of seeing haloes around lights, especially at the end of the day?
MR. ADAMS: Object to the form, but go ahead.
A. Not -- Rarely.
Q. Rarely?
A. I can't remember a patient that wore contact lenses that's said they saw haloes.
Q. Do people who have allergy eyes experience haloes around lights?
A. Not any of my patients that I can recall.
Q. Can people who have a scratch on their cornea experience haloes around lights?
A. They usually complain of eye pain and feeling

Page 106

like there's a foreign body sensation in their eye. They don't complain about haloes.
Q. What about somebody who is suffering from conjunctivitis? Would they experience haloes around lights?
A. No.
Q. No?
A. It would be very atypical.
Q. So your testimony is that just about every time somebody complains about haloes around lights it has to do with increased intraocular pressure?
A. Causing the cornea to swell. And I'd also like to say that the most important reason that an optometrist needs to look at that's causing haloes around lights is angle-closure glaucoma. That's a red flag that that's -- It's a red flag that this may be happening and I've got to do everything to make sure that it's not. So I'm testifying also that it's very important to rule out angle closure since it can be so devastating visually to the patient.

Page 107

Q. Can cataracts also cause haloes around lights?
A. Usually causes patients to see colors, such as -- Sometimes it causes them to see yellows. I mean, a lot of the -- or they see colors differently. That's why a lot of older ladies have -- their hair is an unusual color sometimes.
Q. But cataracts in your opinion would not cause a complaint of haloes around lights?
A. It would be pretty rare to cause that complaint.
Q. What is Corneal Endothelial Dystrophy?
A. That's what I talked about before about there's some mild swelling. The endothelium is the layer on the back of the cornea. It's actually called Fuch's, F-U-C-H-'S, Corneal Dystrophy. Occurs in older patients, and their endothelium is not working correctly so they get mild edema.
Q. Would that cause a complaint of seeing haloes around lights?
A. My patients with Endothelial Dystrophy complain about blurry vision.

Page 108

Q. What if someone had a mucousy eye for whatever reason? Would that cause haloes around lights?
A. That's usually a sign of allergic conjunctivitis. I can't recall a patient ever with that common entity saying they had haloes around lights.
Q. Would any type of drugs to your knowledge cause a complaint of seeing haloes around lights?
A. Again, very atypical. I haven't had a patient that was on a drug systemically or topical that caused them to see haloes around lights.
Q. What is Digitalis?
A. That's a cardiac glycoside.
Q. Have you ever had a patient on Digitalis --
A. I have --
Q. -- complain of seeing haloes around lights?
A. I have had a patient on Digitalis but never one that complained about seeing haloes around lights.
Q. What is Chloroquine?
A. That's an anti-malarial, and you're worried

Page 109

about a toxic maculopathy. That would be the number one reason you're worried about Chloroquine. Actually one of my legal cases before was about Chloroquine maculopathy, and it causes corneal problems. It causes a vortex keratopathy, but that does not have anything to do with swelling.
Q. Chloroquine would not cause an effect of seeing haloes around lights?
A. It would be very atypical, rare, unusual.
Q. What is Psuedophakic Bullous Keratopathy? I'm sure I murdered that.
A. You did fine.
Q. What is that?
A. Pseudophakic means you've had cataract surgery so it means you have a fake lens in the eye. And rarely patients can develop problems with their endothelium after cataract surgery, and it can be severe and it can cause the endothelium to swell and to bubble up. Again, my patients with that -- That's a really rare entity because the cataract surgery is so good nowadays. I've had one patient with that in

Page 110

the past ten years, and they complained about blurry vision.
Q. Have you ever had a patient who suffered from that disease, Pseudophakic Bullous Keratopathy, who complained of seeing haloes around lights?
A. I have not.
Q. Is it important as an optometrist to take an accurate history from a patient?
A. Yes.
Q. Why is it important?
A. Because the symptoms -- you want to know why they are there in terms of their chief complaint so you can address that in your assessment. You want to know what's happening in terms of their eyes or what's happened in the past in terms of their ocular history. You want to know about their medical history, too, because that relates directly to how your exam -- what may result in your exam and what you need to look for.
Q. If a patient had a history of trauma to the eye or trauma to the region immediately

Page 111

surrounding the eye -- Is there a word that y'all use for this area immediately around your eyes and nose?
A. Adnexa.
Q. I'm sorry?
A. A-D-N-E-X-A.
Q. Would it be important if a patient had suffered trauma to the adnexa for him to report that to his optometrist?
A. Yes.
Q. Why is that important?
A. Just because we need to know about that. Sometimes -- Most of the time what happens is I see something in the patient that may indicate that they've had a past trauma. And then they go, oh, yeah, like 25 years ago I got hit with a fist. Often they don't -- We ask about trauma in our history, but often they don't realize what kind -- we mean any type of trauma. But if they report it, then we rule out all the things that might have been hurt in the eye that cause trauma.
Q. I think you may have said this earlier, but

Page 112

trauma can -- trauma to the eye can lead to angle-closure glaucoma, can it not?
A. Angle-recession glaucoma, not angle-closure glaucoma.
Q. Trauma would lead to angle-recession glaucoma?
A. Yes.
Q. Why would it not lead to angle-closure glaucoma?
A. Because usually what happens with trauma, that angle kind of doesn't drain correctly but it pulls the iris away. So when you do gonioscopy, you see a wider open angle. It's just not working correctly. And generally the pressure works like in regular glaucoma or open angle. It's going to gradually become elevated over time as opposed to being an acute kind of condition.
MR. WHITE: I need to take a break real quick.
(Brief recess.)
Q. (Continuing by Mr. White) Mr. Bengston also at some point complained of a film over his eye. What is that a symptom of in your opinion?

Page 113

A. Usually a dry eye.
MR. ADAMS: I'm going to issue a late objection on that. Object to the form of the question.
Q. And your answer was what?
A. Usually a dry eye, but it has a lot of other causes too.
Q. What are some of those other causes?
A. Film could mean blur so it could be refractive error. Could be a problem with their eye health, their cornea or any other part of the eye, including the back of the eye.
Q. When you use the term "elevated intraocular pressure," at what number is a person's intraocular pressure elevated?
A. Greater than 21.
Q. So anything greater than 21 is elevated; is that right?
A. Yes.
Q. Is that commonly accepted among optometrists, that that number is where it becomes elevated?
A. Yes.
Q. And then the term "asymmetric intraocular

Page 114

pressure," what does that mean?
A. Greater than 5 millimeters difference between the eyes of the intraocular pressure.
Q. And that's at a single visit --
A. Yes.
Q. -- at a single point in time?
A. Yes.
Q. Is that also generally accepted in the optometric community as being the number to use, that 5 milliliter --
A. Five millimeters, yes.
Q. I'm sorry. You're talking about millimeters of Mercury?
A. Yes.
Q. Let me ask you about the noncontact tonometer, and that's also known as the air puff test; is that correct?
A. Yes.
Q. And oftentimes we see it abbreviated as NCT; is that correct also?
A. Yes.
Q. Is the noncontact tonometer still used in optometrists' offices?

Page 115

A. Rarely.
Q. Rarely?
A. Rarely.
Q. Do you have one in your office?
A. There may be one at the college.
Q. May be one at the college?
A. Yeah.
Q. Do y'all use it to evaluate intraocular pressure?
A. I don't.
Q. Does anyone at your college use it to evaluate intraocular pressure?
A. Rarely.
Q. What do you mean by rarely?
A. If there's no way we can get a Goldmann applanation tonometry reading, then there are other measures to try tonometry. One of them would be NCT.
Q. What is the basis for you saying that the NCT is rarely used in optometrists' offices?
A. It's not the standard of care to measure tonometry.
Q. What's your basis for making that statement

Page 116

that the NCT is not the standard of care?
A. It's not as accurate. When I administered the boards for the profession of optometry, the clinical national board of examiners in optometry, the graduating exam that students take during the fourth year -- and they take it at all the optometry schools in the country; most states utilize that for their way for students to get licensed -- noncontact tonometry has never been on that board. In the past 15 years, Goldmann tonometry is the only thing that's been on that board for a way to measure tonometry.
Q. Isn't it true that many, many optometrists still use the noncontact tonometer to measure intraocular pressure?
MR. ADAMS: Object to the form. Go ahead.
A. The only three that I'm aware of are the three that the -- Dr. Bazemore, and then the other two that you got to speak on his -- to be his expert.
Q. So your testimony is the only three

Page 117

optometrists in the universe that you know of who still use NCT are Dr. Bazemore, Dr. Murphy, who is our expert, and Dr. Basden, who is also our expert?

MR. ADAMS: Object to the form. Go ahead.

A. Who would use that as their primary means to measure intraocular pressure. If for some reason, again, you don't have a patient that can be measured with the Goldmann, then there perhaps are some optometrists that have an NCT in their office. The reason the NCT was around was so that optometrists could measure pressure in the 1970s before topical drugs were allowed to be used by optometrists to measure intraocular pressure. So that was a way for us to do that. But as soon as topical drugs were allowed to do that, since Goldmann has been proven over and over again to be so much more accurate than -- It has been taught for the past 20 years that that's the standard of care.

Q. Been taught by who?

Page 118

A. The optometry schools at continuing education conferences.

Q. What writings are you aware of or what peer review articles are you aware of that state explicitly that the noncontact tonometer is not to be used for primary -- for diagnosing primary intraocular pressure?

A. I would have to go back to the mid-'80s when I went to optometry school because that's when the literature came out on that, and it was pretty much settled then. But I'm not aware -- I'd have to look up those articles. Since I've been in optometry, no one has ever advocated utilizing that if you don't have to as a means to measure intraocular pressure in all the educational institutions I've been at.

Q. Let me make sure I understand you. Is it your testimony that most optometrists -- practicing optometrists simply do not have these devices in their office?

MR. ADAMS: Object to the form. You can answer.

A. They are taught -- I don't know. They are

Page 119

taught that that's not an accurate -- there are much more -- there's a much more accurate way to measure tonometry. To best take care of your patient -- this is all about the patient -- they expect the doctor to use the best method to check for intraocular pressure to make sure they don't have glaucoma. This is about the patient. They have been taught that that is the standard of care for tonometry.

Q. In your opinion, how inaccurate is the noncontact tonometer?

A. It's inaccurate. I don't know what percent of the time it's inaccurate. If the accuracy of the Goldmann is 100 percent, that one is 50 percent.

Q. Is the accuracy of the Goldmann a hundred percent?

A. I said if the accuracy --

Q. That's what I'm asking you. Is that true?

A. I think it's the best way we have now to measure intraocular pressure.

Q. Are there not better ways than Goldmann to

Page 120

pressure the pressure?

A. You can measure it with pachymetry, and then you can adjust the Goldmann based on that if you want to do that.

Q. Isn't the Goldmann also subjective?

A. No, it's not subjective at all.

Q. It's not?

A. No. The patient sits there, and you put a drop in and they open up their eye. And you put the probe on the front of the cornea, and you turn it until you get the mires lined up correctly.

Q. Where the mires line up is where the pressure reading is?

A. Yes.

Q. And --

A. The inside mires.

Q. And isn't it subjective from one optometrist to the other as to where those line up?

A. The inside mires are supposed to line up. When you're testing on Goldmann tonometry on a national board, we watch through a teaching tube to make sure the optometrist is lining up

Page 121

the inside mires. It's not a hard procedure to do. Everyone that graduates from optometry school can do Goldmann tonometry.
Q. If a Goldmann -- Let me ask this. If a noncontact tonometer read 13 and you did a Goldmann's, where would the Goldmann's read?
A. I don't know. It would read what I believe the pressure to be in the patient's eye. I can't compare one to the other. If the patient's pressure was 28, then I believe the Goldmann would read 28.
Q. The question I'm asking you is, are you aware of any studies or papers that talk about the difference between the Goldmann's tonometer and the noncontact tonometer?
A. I'm sure there are studies on that. Again, they would be from the 1980s because this has been established a long time ago that it's much more accurate.
Q. Now, I understand that you say it's been established that the Goldmann's is much more accurate, but has it been established in your opinion that optometrists should not use the

Page 122

noncontact tonometer to evaluate intraocular pressure?
A. Yes. If we're testing students when they graduate for the past 10 or 15 years on 20 skills that we think are most important to them in terms of the national boards and if one of those skills is Goldmann tonometry, then that's what we expect the graduate to do on the patient.
Q. Do you test them -- ask them a question about whether or not they should use the noncontact tonometer?
A. No.
Q. That question is not asked?
A. No.
Q. Do you ever have an opportunity to go around and visit optometry clinics? I'm talking about private optometry clinics.
A. Not a lot. The only way I would know about private optometry clinics would be from students e-mailing me and asking me questions and such. Everywhere I've worked, including when I -- That wouldn't be a private optometry

Page 123

clinic, I guess, substituting at those stores like I mentioned. Those all had Goldmann tonometers.
Q. What is your basis, then, for testifying that the noncontact tonometers are not used by optometrists anymore?
A. Because they are not accurate to measure intraocular pressure.
Q. I understand -- I appreciate you telling me that they are not accurate. What is your basis for concluding that practicing optometrists do not use them anymore?
MR. ADAMS: Object to the form. Hasn't that been asked and answered?
MR. WHITE: No, I don't think he's -- I've asked it and he hasn't --
A. Because I don't know anyone in practice that utilizes noncontact tonometry on a regular basis to measure pressure on their patients.
Q. So that's based upon the universe of people that you know in private practice?

Page 124

MR. ADAMS: Object to the form.
A. It would be based on every student that I've taught, the 120 per year for the past 10 or 15 years that I've taught to use Goldmann tonometry.
Q. And they always do what you teach them to?
MR. ADAMS: Object to the form.
A. This is not -- Goldmann -- It's not a difficult thing to do. It's the minimum standard of care to measure tonometry, to make sure you're getting an accurate reading on the patient. If you were worried about glaucoma and your optometrist was measuring it with an NCT, then the optometrist, he or she might miss glaucoma and the patient ultimately would suffer because you're not using the most accurate means to do it. I can't force anyone to do anything they want, but if they are not -- if a patient suffers because I don't believe someone is doing the standard -- minimum standard of care, then my opinion would be that that would be a reason why the patient suffered in terms of Goldmann

Page 125

tonometry.
Q. I didn't catch that. Say that again. I don't know that I followed that answer.
A. It's about the patient.
Q. Right.
A. I believe that Mr. Bengston did not at every visit when he saw Dr. Bazemore have his pressure measured by Goldmann tonometry. So since Dr. Bazemore was not using the current measure, the current manner to measure intraocular pressure, then the patient's intraocular pressure measurement was not as accurate as it could be.
Q. Do you know how inaccurate it was?
A. No. Because it wasn't a Goldmann tonometry reading. There was lots of -- The patient had already lost tons of visual field by the time he ended up in Dr. Sepanski's office. He had a small island of vision, so I'm concerned that the pressure in the past had been elevated.
Q. Do different other medical schools, other optometry schools, teach their students how to

Page 126

use the noncontact tonometer?
A. I don't know. I know that everyone teaches them how to do Goldmann tonometry, and I know they are tested on Goldmann tonometry for all their practicals as they go through the optometry school.
Q. Do you at your school teach how to operate the noncontact tonometer device?
A. They may have -- There may be one in the central testing part of the clinic, and they may briefly get that once during their four-year tenure. And I'm not even sure if there's a noncontact tonometer there.
Q. Why not just throw it out if it's such an antiquated device?
A. The old ones that we have are sitting in our storeroom. This may be -- I'm not familiar with what's in central testing. It's not a traditional NCT. There are other ways to measure tonometry if you can't get Goldmann tonometry. They are not as accurate, but if we can't, we have to have another measure.
Q. So you would use -- would there ever be a

Page 127

situation where you would use the NCT as a fallback to measure intraocular pressure?
A. I would use a Perkins tonometer, which is a handheld tonometer. It's a lot less threatening to the patient, and it can get a reading for you too.
Q. Would there be any situation where you would use a noncontact tonometer?
A. On a 6-year-old or younger that I couldn't get a Goldmann tonometry on after I attempted it.
Q. Do you have an understanding of the degree of inaccuracy there is with a noncontact tonometry?
A. I know it's very inaccurate.
Q. But to what degree? In other words, if an NCT said 13, are you going to do a Goldmann's and it's going to be 32 or is it going to be 15?
A. I just would never do an NCT. I would do something else besides the Goldmann, but I wouldn't do an NCT.
Q. So is the truth of the matter you don't know how inaccurate they are? You just believe them to be inaccurate?

Page 128

MR. ADAMS: I'm going to object to the form because you're asking him if -- I mean, if there was a standard set inaccuracy -- I mean, if it was always 10 points differential, then it would be accurate. If you could rely on it to be this much different than Goldmann's tonometry --
MR. WHITE: That's what I'm asking him.
MR. ADAMS: -- then you'd know what the pressure was. But he's saying it is inaccurate. It's inconsistent. He's said that for a while now.
A. At one time it could read 33, and the pressure was 10 and next -- the Goldmann pressure was 10. And the next time the Goldmann pressure on a different patient could be 20, and it could read 12.
Q. Are you just making that up or is that --
A. No. I can think of --

Page 129

MR. ADAMS: Object to the form.
A. I can think of times when that's happened years and years ago.
Q. Really?
A. Yeah.
Q. What patient was that?
A. I don't remember.
Q. But you remember about a 33 and a 12, but you don't remember the patient?
A. I remember that during optometry school when I went from 1984 to 1988, I learned how to do Goldmann tonometry because I was taught over and over that noncontact was inaccurate, and this is a much more accurate way to do tonometry. And that's why it's the standard of care in our profession.
Q. Are you aware of any articles or any writings that say, in essence, that the noncontact tonometer should not used?
A. I'd have to look that stuff up.
Q. As you sit here today, you're not aware of any such articles?
A. I would say that there's a hundred percent

Page 130

chance that there would be an article that said that Goldmann's should always be used if possible versus noncontact tonometry because it's so inaccurate.
Q. Are there any -- Are you aware of any statistics regarding the usage of the noncontact tonometer by optometrists currently?
A. I'm not currently aware of any.
Q. What is the slit lamp exam?
A. That looks at the health on the front of your eye so you would be looking at the lids and the lashes. You would be looking at the cornea, the lens, the iris, the conjunctiva. Everything you can basically see, only it would be a magnified view. The patient sits behind an instrument that gives you a magnified view of all those structures.
Q. Is that also known as the Von Herrick's test?
A. That is part of it.
Q. What is that?
A. That's a screening to check to make sure it's okay to dilate your patients.

Page 131

Q. What are they screening for?
A. They are screened to make sure that the angle is open enough to dilate the patient.
Q. Okay.
A. So there's a beam of light with the slit lamp, and you put that beam of light at the edge of your iris. And you'll see a shadow there, and the shadow, if it's a certain width, it's going to be okay to dilate your patient without closing the angle.
Q. Do optometrists use the Von Herrick exam to determine whether an angle is open or closed?
A. They utilize it to determine whether it's okay to dilate the patient or not.
Q. Is it your opinion that you would not use the slit lamp exam to evaluate the open or closed nature of the angle?
A. No. Because for glaucoma, the standard of care is you put a gonioscopy lens on to determine the type of glaucoma the patient has. That's initially when you make that diagnosis. That is a gross screening, the Von Herrick, very gross.

Page 132

Q. That's a what screening?
A. Gross, meaning that it's -- it basically tells you that the angle looks kind of normal so it's okay. You're not going to have any problems dilating the patient. Sometimes when we dilate patients, the dilating drops can actually narrow up the angle a little bit.
Q. Is it your testimony, then, that you would do gonioscopy on every patient?
A. No.
Q. Under what --
A. I would do it on any patients that I suspect of having glaucoma.
Q. You would do it on every patient you suspected of having glaucoma?
A. Right.
Q. And I believe you testified earlier that complaining of haloes around lights is a red flag, and you would do a full examination for glaucoma; is that right?
A. Yes.
Q. If you can grade with the slit lamp exam whether the angle is open, why do the

Page 133

gonioscopy? What does the gonioscopy show you?

MR. ADAMS: Object to the form, but go ahead. You can answer.

A. It shows you the actual structures in the angle. You're viewing the structures directly so you can see the trabecular mesh, ciliary body, Schwalbe's line and other structures. So there are structures that you can view with gonioscopy that you are not seeing with the Von Herrick estimation. It's called a Von Herrick Angle Estimation Test.

(Defendant's Exhibit 4 marked for identification.)

Q. I'm going to hand you what I've marked as Defendant's Exhibit 4, which is the four office visit notes from where Mr. Bengston visited Dr. Bazemore. And I'm going to ask you a few questions about that. They are dated -- The last visit of August 20, 2004 is on top.

A. Yes.

Q. I want to ask you a few questions about that.

Page 134

The pressure on this visit, as I understand it and what Dr. Bazemore has testified to, is 13 and 12. Do you see that on there?

A. Yes.

Q. And he's testified that that was done via the noncontact tonometer. Do you agree that that was Mr. Bengston's pressure on August 20, 2004?

A. By NCT, yes.

Q. Do you disagree that that was his actual eye intraocular pressure on that date?

A. I'm not sure. I'd have to know what the Goldmann tonometry was. The chance of accuracy with that is going to be much less than if you would have done Goldmann tonometry.

Q. So as we sit here today, can you tell me what Mr. Bengston's actual intraocular pressure was on 8/20/04?

A. No.

Q. If Goldmann's had been done on that date, what would it have shown?

Page 135

A. It could have shown any pressure because he could have had intermittent angle closure, meaning that the pressure could have been high on this date or it could have been normal. I don't know here if he was seeing haloes at this -- He said seeing haloes around lights is worse at night. If he was seeing haloes at this time when he actually came in, then I would expect the Goldmann to be much higher than this. But you can have intermittent angle closure where the angle is narrow, and it can close and open on its own and the pressure can go up temporarily.

Q. So if the Goldmann's -- Bottom line is that if the Goldmann's had been done, you don't know what it would have shown on that date; is that correct?

A. No, I don't.

Q. Could it have been 13 and 12 on the Goldmann's as well?

A. I guess.

Q. The angle on that date -- Dr. Bazemore graded his angle as being open on that date. Do you

Page 136

agree? Is that reflected in the notes under the slit lamp exam?

A. See, I had trouble reading this. I need to know what this says. This is hard to read, a lot of the writing here. This says lid, I think, OD. This says -- There's a slash and then it says -- I can't tell if that's a 13/4 and maybe there's a GR 40U. But 1 3/4, I don't know what that means.

Q. Well, Dr. Bazemore testified to that in his deposition, and I believe he said that the 4 indicated that the angle was wide open.

A. By estimation.

Q. Yes.

A. By the Von Herrick.

Q. Right. Do you have any reason to disagree with that?

A. The estimation of the angle, if he wrote that down and he knows how to do that technique, then, sure, I agree.

Q. Do you have any basis to disagree that Mr. Bengston's angle was wide open on that date? Is 4 wide open? Isn't that -- I use

Page 137

the term "wide open". Is 4 a number for grading openness in an angle?
A. It's an estimate that it's open. Considering the patient didn't have open angles when he came to Dr. Sepanski's later on in that he had a complaint that was indicative of a narrow angle, haloes, I don't -- I wish I would have the gonioscopy readings here to really tell me what was the angle -- really tell me what was going on with the angle.
Q. Let me back up. You said given that he didn't have open angles later on. What do you mean by that?
A. When he went to see Dr. Sepanski six months later.
Q. What did Dr. Sepanski say?
A. He had some form of angle-closure glaucoma.
Q. Isn't it true that Dr. Sepanski also graded his angles as being wide open?
A. His angles were closed or they were narrow because they had peripheral anterior synechia in them. So that was preventing the fluid from draining out. You can't see the

Page 138

peripheral anterior synechia and that inflammation without doing gonioscopy.
Q. I'm talking about the openness of the angle itself, regardless of something clogging up the mesh work in there. I'm talking about the degree of openness of the angle.
A. As screening for the angle being open, he said the 4 indicates that it's open as a screener.
Q. You're saying "he". Are you talking about Dr. Bazemore?
A. Yes.
Q. And isn't it true that Dr. Sepanski also graded the angle at 4 six months later as being open?
A. You can grade it -- Did he grade it via the slit lamp exam or did he grade it via gonioscopy as a 4?
Q. I don't know. Do you know that?
A. I'm not sure, but I know in his assessment it said angle closure at that first visit.
Q. And you disagree with that assessment by Dr. Sepanski of angle closure?
A. No, I don't.

Page 139

Q. I thought you told me it was angle-recession glaucoma.
A. No, I never said that.
Q. So you agree that it's angle-closure glaucoma?
A. That it's some type of angle closure, yes.
Q. Going back to this doctor's -- Dr. Bazemore's notes of 8/20, what reason do you have to disagree that the angle was open on that date?
A. Because there's no definitive way to look at the angle here besides the screening test, which is a very gross test. No one has looked at the angle structures so I don't know what they are.
Q. You don't know what they are?
A. Right.
Q. Is that correct?
A. Right. Because he didn't do the test that's required to know what the angle really looked like.
Q. And if you had done the gonioscopy on that date, you don't know what you would have found on that date, do you?
A. Based on the fact that the patient was

Page 140

reporting haloes around lights and he ended up losing most of his vision except for a small island of vision, I bet the angle would have looked unusual to Dr. Bazemore.
Q. You bet it would?
A. Yeah. It would have to me.
Q. And you know that based upon looking at his medical records from later on, correct?
A. And the fact that patients don't complain about -- For a patient to actually come in and say, I have haloes around lights -- You know, we talked about the film, and that could be an indication. Just based on this, without having Dr. Sepanski's records, that's what I was telling you earlier today, that I said I bet this patient ended up with an angle closure.
Q. How quickly can an angle closure develop?
A. Within hours. But then it can go away on its own spontaneously. It can be intermittent. So you really need to know what the angle looks like.
Q. Isn't it true that when Mr. Bengston went to

Page 141

see Dr. Sepanski six months later, his angle closure could have developed within hours of seeing Dr. Sepanski?
A. That one, yes. But if it had developed -- you've got -- His visual field indicates end stage glaucoma. He has hardly any vision left except for a central island. That doesn't occur within hours. That takes longer to occur.
Q. His visual field has depleted to that level currently, correct?
A. No. It was already that way when he saw Dr. Sepanski.
Q. What was his vision when he saw Dr. Sepanski?
A. It was about 20/30.
Q. And you're telling me you think the 20/30 is a result of glaucoma?
A. I believe so, yes.
Q. What is your basis for believing that the 20/30 is from glaucoma?
A. Because there was no other indication in the record. There's a lot of reasons why you can lose your vision. You could have a cataract.

Page 142

You could have a problem with the macula in the back of your eye which is part of the retina that allows you to see very well. There's a lot of reasons why patients can't see 20/20 vision. The only thing that showed up in the record was the extensive visual field loss. You have to have a lot of visual field loss in order to actually lose lines of visual acuity, and the normal would be 20/20. So that would be two lines of visual acuity. There was nothing else in that record at that time that would have been an etiology for the vision loss.
Q. The record in front of you of 8/20/04 also talks about examining his pupils. Dr. Bazemore testified that on that date, his pupils were equal in appearance and equally reactive to light. Do you have any reason to disagree with that finding?
A. In Dr. Bazemore's deposition, he said that there's no difference between using a pen light and a transilluminator to do pupils. Transilluminator is the standard of care and

Page 143

not a pen light to do pupils.
Q. So you think he should have used a transilluminator?
A. And I don't know if he did or not. It doesn't say here, and I didn't -- The only reason that that concerns me is in his deposition, he said that the transilluminator is the same as using a pen light; it doesn't make a difference which one you use. And that's not -- The patient did end up with an afferent pupillary defect when he showed up at Dr. Sepanski's office. And that's a lot harder to see with a transilluminator versus a -- Excuse me. That's wrong. They are a lot harder to see with a pen light versus a transilluminator.
Q. So tell me what evidence you have to say that Dr. Bazemore's findings on August 20, 2004 that Mr. Bengston's pupils were equal and equally reactive to light was inaccurate.
A. It says that here. The only concern I have is in his deposition, I don't know whether he used a pen light or a transilluminator.
Q. If he had used a transilluminator, in your

Page 144

opinion what would he have seen differently?
A. It will be easier to see an afferent pupillary defect.
Q. Do you know as we sit here today whether Mr. Bengston had an affery pupillary defect --
A. Afferent.
Q. -- afferent pupillary defect on August 20, 2004?
A. He wrote down no.
Q. And you don't have any evidence to suggest otherwise, do you?
A. It just concerned me, again, because of his deposition, what he said about that.
Q. Mr. -- I'm sorry. Go ahead.
A. Because he did end up with an afferent pupillary defect.
Q. Dr. Bazemore also testified that he looked at Mr. Bengston's optic nerve on that date and that it appeared normal. Do you have any reason to disagree with Dr. Bazemore's findings in that regard?
A. He put .4 and .35 here for CDs. Those are normal cup to disc ratios. I don't see any

Page 145

comment regarding the neuroretinal rim, which is the -- The optic nerve is like a doughnut, and the hole in the center is the cup. And that's the cup size, .4 and .35. That's normal. But what is just as important in glaucoma is that you evaluate the neuroretinal rim, and there's no comment here on that. But the CDs look normal.

Q. Do you have any evidence to suggest that the optic nerve did not appear normal on Mr. Bengston's visit of August 20, 2004 to Dr. Bazemore?

A. All you can say is that the CD was normal, cup to disc ratio, .4 and .35. There's no other comments here about other parts of the optic nerve that are evaluated typically on patients.

Q. Let me hand you back Defendant's Exhibit 3. I want to ask you some questions about that.

A. Of course.

Q. In paragraph 2 on Defendant's Exhibit 3, you talk about the medical records you've reviewed, and you talk about reviewing

Page 146

Dr. Bazemore's notes and Dr. Bengston's notes -- I'm sorry -- Dr. Sepanski's notes, correct?

A. Yes.

Q. So are those the only two doctors' notes you had reviewed at the time of formulating your written report in this matter?

A. Yes.

Q. And you begin at the bottom of page 2 by saying, the optometrist, Dr. Bazemore, failed to meet the standard of care in regards to the history and exam findings in this patient.

What is the standard of care in this situation?

A. If a patient has haloes around lights, you have to make sure that they don't have angle closure.

Q. And where would I find that written down somewhere, what you just said, as being the --

A. In the Clinical Ocular Pharmacology book by Bartlett and Jaanus.

Q. You say if a patient complains of haloes around lights, you have to make sure they

Page 147

don't have angle closure; is that correct?

A. That would be the most important condition to rule out because it's the most devastating condition to the patient's vision that causes haloes around lights as a symptom.

Q. How would you go about making sure that they don't have angle closure?

A. Measure Goldmann tonometry and do gonioscopy.

Q. Could you imagine a scenario where a patient came in and complained of haloes around lights and then when you did Goldmann's had normal pressure and when you did gonioscopy found that he had no blockages of any kind or closures?

A. Yes.

Q. Tell me what kind of scenario that would be.

A. Anything that causes a severe corneal edema, maybe the Pseudophakic Bullous K. But I would write down in my assessment the reason for that, and my plan would include the treatment and then have the patient come back to make sure that they were better.

Q. Any other scenario you can imagine where

Page 148

somebody complained of haloes around lights but tested normal on Goldmann's and normal on gonioscopy? There would be a lot of different scenarios, wouldn't there?

A. They would be really rare in that you'd have to write them down in your assessment that that was the reason why and then have them back and make sure that is the reason why.

Q. The next sentence in your report reads, on August 20, 2004, Mr. Bengston complained of haloes around lights in the right eye. The next sentence is, this, combined with an exam history finding of asymmetric and elevated intraocular pressure in the right eye is highly indicative of narrow-angle or angle-closure glaucoma.

Tell me where in his history there was asymmetric intraocular pressure.

A. When I said exam history, I was referring to the reading from the exam on 10/2/01.

Q. And so that's a visit by Mr. Bengston almost three years prior; is that correct?

A. Yes.

Page 149

Q. And on that date, there was a noncontact tonometer performed at 3:50 p.m., which says 38 and 24; is that correct?
A. Yes.
Q. 38 being the right eye and 24 being the left eye?
A. Yes.
Q. Do you remember if I asked you earlier if that had been scratched out?
A. You did.
Q. Does that appear to be scratched out?
A. There's a scratch through it. I wasn't sure when I went through the records that that was scratched out, because when you -- the standard of care for scratching out things in the records is to cross it out, initial and date it, especially for a tonometry reading.
Q. And what does this say over here on the side? Can you read that?
A. Lids and then -- This is tough for me to read.
Q. You've indicated today that you've read the deposition of Dr. Bazemore. Do you remember what he said about that in his deposition?

Page 150

A. He said that the patient was squeezing his lids.
Q. In your experience, is that one of the issues with the noncontact tonometer that can give a false high reading if somebody is squinting their eyes at the time the test is given?
A. From what I remember is that it won't give you a reading if it's not accurate, if it's not considered within the accuracy of the NCT.
Q. That's what you remember about it from back in the '80s?
A. Yes.
Q. And did you remember Dr. Bazemore's testimony that he then did a Goldmann's tonometry on this visit of 10/2/01?
A. Right. I can see that there, too.
Q. Isn't that what's circled out here to the side, the 20 and the 19?
A. Right.
Q. Do you remember also that he testified that he did not rely upon the 38 and the 24?
A. He said 28 and 24 in his deposition.
Q. Did he testify that he did not rely upon that?

Page 151

A. I think so. I don't ...
Q. Under the Goldmann's standard of 20 and 19 that's listed here on 10/2/01, is that considered elevated pressure?
A. 21 is high. The 20 is on the high side of normal.
Q. The 20 and 19, are those considered asymmetric pressures?
A. No. But the reason for this in the record was because of this, and the right eye ultimately was the one that was affected with angle closure. And a 14 difference, you know, I was concerned about this reading, and that's why I put it in here.
Q. The reference in your report, Exhibit 3 -- In Exhibit 3, the reference to asymmetric and elevated intraocular pressure in the right eye, is that reference only to this entry on the 10/2/01 visit where it looks to say 38 and 24?
A. Yes.
Q. There's no other evidence in Mr. Bengston's records that you're aware of that show either

Page 152

elevated intraocular pressure or asymmetric intraocular pressure; is that correct?
A. Not in these four records, no.
Q. Are there some other records that would indicate that that you know of?
A. Just the ones when he saw Dr. Sepanski, but not in these four.
Q. And on the visit of 10/2/01, Mr. Bengston was not complaining of haloes around lights on that occasion, was he?
MR. ADAMS: Object to the form. He can't ...
A. Again, I'm having trouble reading the chief complaint. Last check, check new glasses. I don't know what this says. Chief complaint, wants contact lens, never worn. There's nothing that I can see about haloes here.
Q. Have you since had an opportunity to review the records from Dr. Reed Cooper?
A. Yes.
Q. Do you have any opinions about his treatment of Mr. Bazemore?
A. He is the patient's primary care physician.

Page 153

He saw him twice?
Q. Yeah.
A. I think the patient had a different problem in the other eye like a conjunctivitis that he was working on, but he --
MR. ADAMS: I'm going to object.
A. If I can remember --
MR. ADAMS: Hold on just a second. I'm going to object to the form of the question to the extent you're asking him to critique care provided by a medical doctor, a family practitioner. He is being presented as an expert professor of optometry, and he's not purported to be a medical doctor. And so to ask him to testify as to a medical doctor's -- to critique a medical doctor is not appropriate.
Q. Let me ask you this way. Are you familiar or do you know what is the standard for medical doctors in dealing with patients who present

Page 154

with eye problems?
A. No. I see a lot of patients that have seen medical doctors that had eye problems and then end up in my clinic. That's all. I was glad to Dr. -- I keep getting -- Dr. Cooper. I was glad that he got him to Dr. Sepanski. That's the only thing that I was ...
Q. So going back to your report on Exhibit 3, the sentence that reads -- Well, starting up here, on August 20, 2004, Mr. Bengston complained of haloes around lights in the right eye. And then you say, this, combined with an exam history finding of asymmetric and elevated intraocular pressure in the right eye, is highly indicative of narrow-angle or angle-closure glaucoma.
We just talked about the asymmetric and the intraocular pressure. If you were to assume for purposes of this question that there was no asymmetric or elevated intraocular pressure, would the single complaint of haloes around lights be highly indicative of narrow-angle or angle-closure

Page 155

glaucoma?
A. It would be the most important thing to rule out.
Q. The most important thing to rule out.
A. Because it's so devastating to the patient's vision.
Q. Would it be the most common cause of haloes around lights?
A. I don't know.
Q. You don't know?
A. (Witness nods head negatively.)
Q. What --
A. It could be a cause. It's the most important cause of a patient complaining about haloes around lights. Patients don't come into my office that often and complain about haloes around lights. For all the other conditions that we talked about, they complain about blurry vision or eye discomfort, but that actual term "haloes" is unusual to hear from a patient.
Q. The next sentence of the minimum workup per the optometric standard of care for this

Page 156

complaint includes an assessment of the anterior chamber angle via gonioscopy and Goldmann tonometry on each visit.
And that minimum standard of care that you've just described, is that what you are saying is in writing in the Clinical Pharmacology book?
A. Gonioscopy and Goldmann tonometry are indicated to check for angle-closure glaucoma, or that possibility.
Q. And the source for that, again, just to make sure I'm clear, is -- your source for that standard of care is Clinical Ocular Pharmacology, the textbook?
MR. ADAMS: Object to the form. Go ahead.
A. Because it talks about haloes as a symptom, and then it goes through the tests that need to be done in that text.
Q. In that text?
A. Yes.
Q. Are you aware of any other texts or any other writings or treatises that say, in effect,

Page 157

that if a patient complains of haloes around lights, the minimum standard workup would include gonioscopy and Goldmann tonometry at each visit?
A. Any text that talks about angle-closure glaucoma or narrow-angle glaucoma is going to have that in there. So the Will's Eye Text that I talked about earlier -- There are tons of textbooks on eye disease. Any textbook on glaucoma, you would look in the section on neuro angle or angle-closure glaucoma, and it's going to talk about haloes around lights as a symptom of that and what tests need to be done to evaluate that.
Q. Did Mr. Bengston have angle-closure glaucoma on 8/20/2004?
MR. ADAMS: Object to the form. Go ahead.
A. I don't know.
Q. Have you had a chance to read Dr. Bazemore's deposition?
A. I did last night for the first time.
Q. Is there anything in there that you disagree

Page 158

with -- that stuck out to you immediately that you disagree with?
A. There were three things.
Q. Tell me what those were.
A. The first was he used Goldmann and NCT interchangeably and said one was as good as the other.
Q. And you disagree with that?
A. I disagree with that.
Q. For reasons we've discussed here today?
A. Yes.
Q. Okay.
A. The other, he said that patients complain about haloes all the time to him, and that's not been my experience at all as an optometrist.
Q. Do you have any reason to disagree with his statement that patients complain to him all the time about haloes around lights other than the fact you haven't experienced the same thing?
A. The fact that if you would ask anyone, I don't think on a daily basis -- If you were to ask

Page 159

any optometrist, they are not going to say that there's always several patients per day that complain about haloes around lights.
Q. So you think he's lying about that?
MR. ADAMS: Object to the form.
A. I don't know.
Q. But your testimony is you have a different experience in that you don't have many complaints of people complaining of haloes around lights?
A. Right. Because -- I don't. That's all I'm saying.
Q. That was number two. What's number three?
A. The issue with -- he thought that the transilluminator and the pen light were interchangeable to measure pupils. If you use a pen light to do the pupil test on the national boards, you don't pass the test.
Q. Is a transilluminator a new device?
A. No.
Q. How long has it been around?
A. I would imagine 30 years at least. It's a much brighter light source. He has one, I'm

Page 160

sure.
Q. You've given me those three things where you disagree with Dr. Bazemore's deposition. Any other things that stuck out to you regarding Dr. Bazemore's deposition?
A. Those were the three biggest issues upon going through it one time last night.
MR. WHITE: I'm going to take a break.
(Brief recess.)
MR. WHITE: I don't have any further questions.
EXAMINATION
BY MR. ADAMS:
Q. What's been admitted, Dr. Landgraf, as Defendant's Exhibit 3, you have had an opportunity to read over that, correct?
A. Yes.
Q. And you agree that that is your report -- your expert report regarding Kyle Bengston and Dr. Bazemore's treatment of him and the events that give rise to this case?
A. Yes.

Q. And further, that is your signature just above the date under paragraph 6 on that report?
A. Yes.
MR. ADAMS: That's all.
MR. WHITE: No follow-up.
(Deposition concluded at approximately 3:00 p.m.)

* * * * * * * * * * * * *

FURTHER DEPONENT SAITH NOT

* * * * * * * * * * * * *

REPORTER'S CERTIFICATE

STATE OF ALABAMA:
MONTGOMERY COUNTY:

I, Pamela A. Wilbanks, Registered Professional Reporter and Commissioner for the State of Alabama at Large, do hereby certify that I reported the deposition of:

DR. THOMAS J. LANDGRAF, O.D.

who was first duly sworn by me to speak the truth, the whole truth and nothing but the truth, in the matter of:

KYLE BENGSTON,



Plaintiff,
Vs.
DAVID BAZEMORE, O.D., and WAL-MART STORES, INC.,
Defendants.
In The U.S. District Court
For the Middle District of Alabama
Eastern Division
3:06-CV-0059-MEF

on Friday, June 15, 2007.

The foregoing 161 computer printed pages contain a true and correct transcript of the examination of said witness by counsel for the parties set out herein. The reading and signing of same is hereby waived.

I further certify that I am neither of kin nor of counsel to the parties to said cause nor in any manner interested in the results thereof.

This 20th day of June 2007.



Pamela A. Wilbanks, Registered Professional Reporter and Commissioner for the State of Alabama at Large.